SUPREME COURT, U. S.
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IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1973

NO. 74-8

J. B. O'CONNOR, M. D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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SUBJECT INDEX

	Page
Opinion Below	1
Jurisdiction.	1
Questions Presented	2
Constitutional Provisions Involved.	2
Statutory Provisions Involved.	3
Statement of the Case	4
Reasons for Granting the Writ . .	14
Conclusion.	45

TABLE OF AUTHORITIES

Cases

Anonymous, People ex rel v. LaBurt, 369 U.S. 428 (1962). . . 11

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Beverly's Case, 4 Co.Rep. 123(b), 76 Eng.Rep. 1118 (K.D. 1603) . . 16

Burnham v. Department of Public Health, 349 F.Supp. 1335 (N.D. Ga. 1972), appeal docketed, No. 72-3110 (5th Cir. 10/4/72) . 23

Collins v. Hardyman, 341 U.S. 651 (1951). 34

Collins v. Schoonfield, 363 F.Supp. 1152 (D.Md. 1973). . 39

Donaldson, In re, 364 U.S. 808 (1960). 11

Donaldson v. Florida, 371 U.S. 806 (1963). 11

Donaldson v. O'Connor, 390 U.S. 971 (1968). 11

Donaldson v. O'Connor, 400 U.S. 869 (1970). 11

Eslinger v. Thomas, 476 F.2d 225 (4th Cir. 1973) . . 39

TABLE OF AUTHORITIES

Cases (Cont.)

Fleming v. Adams, 377 F.2d 975, 977 (10th Cir. 1967); cert. den. 389 U.S. 898 (1967). 35

Fullington v. Shea, 320 F.Supp. 500 (D.Colo. 1970), affirmed 404 U.S. 963 (1970). 34

Greenwood v. United States, 350 U.S. 366 (1956). 28

Hammer v. Rosen, 7 App.Div. 2d 216, 181 N.Y. S. 2d 805 (1959) . 30

Hoffman v. Halden, 268 F.2d 280 (9th Cir. 1959) . . 40

Humphrey v. Cady, 405 U.S. 504 (1972). 14

Jacobson v. Massachusetts, 197 U.S. 11 (1905) 33

Lake v. Cameron, 124 U.S.App.D.C. 264, 364 F.2d 657, 663 (1966). . 25

McGowan v. Maryland, 366 U.S. 420 (1961). 34

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Niklaus v. Simmons, 196 F.Supp. 691 (D.Neb. 1961). . 34

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TABLE OF AUTHORITIES

Cases (Cont.)

Ogden v. Saunders,
12 Wheat. 213, 281-82 (1827) . . 43

Penn Dairies v. Milk Control
Commission, 318 U.S. 261 (1943). 33

Pierson v. Ray,
386 U.S. 547, 555-557
(1967. . . . . 39, 40

Prince v. Massachusetts,
321 U.S. 158 (1944). 33

Rouse v. Cameron, 373 F.2d 451,
457, n. 30 (D.C. Cir. 1966)
. . . . . 22, 23, 28, 30, 35, 44

Skinner v. Spellman,
480 F.2d 539 (4th Cir. 1973) . . 39

Smith v. Clapp, 436 F.2d 590,
(3rd Cir. 1970). 31

Southern Pacific R.R. Co. v.
United States, 189 U.S. 447,
450 (1903) 39

Stachulak v. Coughlin,
364 F.Supp. 686 (N.D. Ill. 1973) 23

Stephens, United States ex rel v.
LaBurt, 373 U.S. 928 (1963). . . 11

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365 F.Supp. 557 (N.D.Ohio 1972). 39

TABLE OF AUTHORITIES

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United States v. Klein,
325 F.2d 283, 286 (2nd Cir. 1963). 27

Welsch v. Likins,
373 F.Supp. 487 (D.Minn. 1974) . . 23

Westberry v. Fisher,
309 F.Supp. 12 (D.Me. 1970). . . . 39

Wyatt v. Stickney, 325 F.Supp. 781
(M.D.Ala. 1971), on submission
of proposed standards, 334 F.Supp.
1341, enforced, 344 F.Supp. 373,
387, Appeal docketed sub non,
Wyatt v. Aderhold, No. 72-2634
(5th Cir. 8/1/73). 23, 26, 44

United States Constitution

Amendment XIV, §1. 2

Federal Statutes

28 U.S.C. §1254(1) 2

28 U.S.C. §1343(3) 3, 12, 34

28 U.S.C. §§2281, 2284 12

42 U.S.C. §1983. . . . . 3, 12, 34, 39

TABLE OF AUTHORITIES

State Statutes and Codes

§47.30.130, Alaska Statutes (1969 Supp.) 42

§7104, California Wel. & Inst. Code (1969 Supp.). 42, 43

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TABLE OF AUTHORITIES

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TABLE OF AUTHORITIES

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Ross, Commitment of the Mentally Ill: Problems of Law and Policy, 57 Mich.L.Rev. 945 (1959) 19

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TABLE OF AUTHORITIES

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Civil Commitment of the Mentally Ill: Theories and Procedures 79 Harv.L.Rev. 1288 (1966) . . . 19

IN THE
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October Term, 1973

No.

J. B. O'CONNOR, M. D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

The Petitioner, J. B. O'Connor, M. D., respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Fifth Circuit entered in the above case on April 26, 1974.

Opinion Below

The Opinion of the Court of Appeals is reported at 493 F.2d 507. No opinion was rendered by the District Court for the Northern District of Florida.

Jurisdiction

The opinion and judgment of the Court of Appeals for the Fifth Circuit were entered on April 26, 1974, and copies

thereof are appended to this Petition in the Appendix. This Petition was filed within ninety days of the above date. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

Questions Presented

(1) Whether there is a constitutional right to treatment for persons involuntarily committed to a state mental hospital.

(2) Whether, assuming there is a constitutional right to treatment, staff members at a state mental hospital are liable for monetary damages in a suit under the civil rights act.

(3) Whether, assuming there is a constitutional right to treatment, the patient in this case waived that right.

Constitutional Provisions Involved

Constitution of the United States of America, Amendment XIV, §1:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State

shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Statutory Provisions Involved

42 U.S.C. §1983:

Every person, who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

28 U.S.C. §1343(3):

To redress the deprivation, under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured

by the Constitution of the United States or by any Act of Congress providing for equal rights of citizens or of all persons within the jurisdiction of the United States.

Statement of the Case

Kenneth Donaldson, the Respondent, was involuntarily committed to the Florida State Hospital, Chattahoochee, Florida, on January 3, 1957, by a county court judge of Pinellas County, Florida, pursuant to Chapter 394, Florida Statutes. The commitment order stated his incompetency was due to paranoid schizophrenia with auditory and visual hallucinations and delusions. The order further stated that Donaldson, age 50, a resident of four years, required restraint to prevent self-injury or violence to others. Two physicians served as the investigating committee for the proceedings.

Prior to the Florida commitment, Donaldson had been a patient at Marcy State Hospital in New York from March 12, 1943, to June 26, 1943. At that time, his problems were described as auditory hallucinations, ideas of reference, and delusions of persecution. The medical description was Dementia Praecox, Paranoid Type, presently called Schizophrenic Reaction, Paranoid Type.

In January, 1957, at the time of his admission to Florida State Hospital,

Donaldson was examined by a Dr. Clark Adair. The examination revealed that Donaldson expressed delusions of persecution for which he blamed "rich Republicans" and believed that the "Foreign Policy Association" had attempted to poison him by placing chemicals in his food. The diagnosis was Schizophrenia, Paranoid Type.

At the time of his admission, Donaldson, a Christian Scientist, requested that no medicine or shock therapy be administered and he consistently refused repeated offers of such forms of therapy during his commitment. In addition, he frequently refused offers of other non-medical forms of therapy as well.

At the time Donaldson was admitted to the hospital in 1957, the Petitioner, Dr. O'Connor, was Assistant Clinical Director. He was in charge of the ward where Donaldson was assigned upon admission. In that position, Dr. O'Connor was Donaldson's attending physician. Dr. Gumanis, a co-defendant below, was a staff physician.

On July 1, 1959, Dr. O'Connor became Clinical Director of the hospital, and later that year, Dr. Gumanis succeeded him as Donaldson's attending physician. Dr. O'Connor was subsequently promoted to Superintendent of the hospital on July 30, 1963, and served in that capacity until he retired February 1, 1971. Dr. Gumanis served as Donaldson's attending physician until April 18, 1967. At that time, Dr. Israel Hanenson became Donaldson's attending physician until Dr. Hanenson's death in the fall of 1970.

From that time until his release on July 31, 1971, Donaldson was treated by Dr. Jesus Rodriquez.

In 1959, Florida State Hospital at Chattahoochee provided services for 1,736,540 patient days per year. In 1970, Florida State Hospital provided services for 1,351,000 patient days per year, compared to 21,790 patient days in the psychiatric section of one of Florida's largest, non-government hospitals, Tampa General Hospital, for the fiscal year 1967-1968.

During Mr. Donaldson's assignment to Department A of Florida State Hospital, there were two doctors available; making a doctor patient ratio, at times, of 560/1000 patients for each doctor. In 1960, two doctors were responsible for 1000 patients. Previously, only one doctor had this responsibility. During Donaldson's stay in Department C of the hospital, there was one physician and one psychiatrist for approximately 800 patients.

In 1970, Florida State Hospital provided services for 1,351,000 patient days per year with a staff of 17 psychiatrists, seven physicians, and four psychologists, a total of 28 legislatively approved treating-type positions. Only 50% of each doctor's time was available for psychiatry. The remainder had to be devoted to medical matters and administration.

The American Psychological Association describes the optimum doctor-patient ratio

to be one psychiatrist for each 50 acutely ill patients and one psychiatrist for each 125 chronically ill patients. There were approximately 200-500 acutely ill patients alone at Florida State Hospital during the time in question here.

Throughout the time Dr. O'Connor was Donaldson's attending physician, Donaldson continued to refuse to receive medication and shock treatment due to religious views. It should be noted that a prior exposure to such treatment in New York had been somewhat successful. This refusal continued when Dr. Gumanis assumed responsibility in 1959. During the approximately six and one-half years Donaldson was in Dr. Gumanis' care, written notes indicate he had consultation with staff doctors at least 51 times. Testimony at trial indicated that many other consultations probably occurred, but were not recorded.

Psychological examinations conducted in 1960 and 1961 showed no significant change from previous findings of incompetancy. During June, 1963, Helping Hands, a Minneapolis group, requested information about Donaldson and sought his release. Dr. Gumanis and Dr. O'Connor denied the suggested release because Donaldson continued to require strict supervision. Psychological tests administered in 1964 continued to show no significant changes in Donaldson's condition. An earlier test, scheduled late in 1963, had been refused by Donaldson.

During January, 1964, a meeting of nine members of the staff recommended

continued hospitalization. The written opinion of the staff, issued following the meeting with Donaldson, found him dangerous to others and recommended further hospitalization. Donaldson complained to a member of the state legislature who subsequently arranged an interview and examination by an independent psychiatrist, Dr. Franklin J. Calhoun. Dr. Calhoun concluded:

> That the results of my examination were in complete accord with the diagnostic evaluation of the hospital staff. This man has the type of mental illness that is most difficult for lay persons to detect. Even a psychologist or psychiatrist could be 'fooled' by Mr. Donaldson unless certain types of psychological tests are included in the evaluation. Unless his condition has greatly improved since my examination, I still feel very strongly that Mr. Donaldson is ill, dangerous to society, and should remain hospitalized.

During the summer of 1964, a Mr. John Lembcke, a certified public accountant, in Binghamton, New York, and a former classmate of Donaldson's at Syracuse University in the 1920's, began seeking Donaldson's release. Mr. Lembcke made four attempts between 1964 and 1968 to obtain Donaldson's release. All requests for release were denied due to the opinion of the staff that Donaldson was

dangerous to himself and others, and required strict supervision and treatment which they believed Mr. Lembecke would be unable to provide.

During 1966, Donaldson again refused a psychological examination and continued to refuse traditional forms of medication and shock therapy, but did participate in mileau therapy, religious therapy and recreational therapy.

On April 18, 1967, Donaldson was placed under the care of Dr. Hanenson who ordered another set of psychological tests. The examination, conducted July 13, 1967, showed no significant improvement in Donaldson's condition. Dr. Hanenson ordered another test sequence on March 13, 1968, at which time Donaldson showed the first signs of improvement since 1957. Possible trial visits were suggested. On March 21, 1968, Dr. Hanenson presented Donaldson to a staff meeting. The staff found improvement in his condition and suggested trial visits. Although Donaldson was approved for trial visits, Dr. O'Connor rejected Mr. Lembcke's suggestions of a complete release.

On September 9, 1968, Donaldson was given to a work assignment and granted grounds privileges. Testing conducted during November, 1969, indicated release at an early date. A report was submitted to Dr. O'Connor on February 6, 1970, and another, summarizing all psychological testing was submitted on March 27, 1970. Another physician, Dr. F. D. Walls,

examined Donaldson and reported unfavorably on March 27, 1970. During the fall of 1970, at the death of Dr. Hanenson, Dr. Jesus Rodriquez assumed the position of Donaldson's attending physician. He evaluated Donaldson and noted that he had again refused to work, had refused group therapy and refused other suggested forms of therapy.

On March 4, 1971, Donaldson was again assigned to a general routine work assignment. On July 1, 1971, Dr. Milton J. Hirshberg assumed the post of Superintendent of Florida State Hospital. He examined Donaldson on July 26, 1971, and declared him to be a schizophrenic, paranoid type, in remission and recommended his release. Kenneth Donaldson was released from Florida State Hospital on July 31, 1971.

Prior to the present case, Kenneth Donaldson had brought fifteen separate petitions for a writ of habeas corpus in the state courts of Florida and lower federal courts.[1] All petitions were unsuccessful and on four occasions Donaldson petitioned this Court for a writ of certiorari.

The series began in 1960 when the Florida Supreme Court denied a writ of habeas corpus refusing to openly state whether there is, or is not, a constitutional right to treatment. This Court

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[1] Birnbaum, Some Remarks on the Right to Treatment, 23 Ala.L.Rev. 623, 635-636 (1971).

denied certiorari. In re Donaldson, 364 U.S. 808 (1960). Similar denials of a writ of habeas corpus were also brought before this Court in 1963. and 1968. Donaldson v. Florida, 371 U.S. 806 (1963); Donaldson v. O'Connor, 390 U.S. 971 (1968).

In 1970, Donaldson, represented by counsel, again sought review of his case. Certiorari was again denied. Donaldson v. O'Connor, 400 U.S. 869 (1970). During this same period, at least three other cases in which various courts had refused to rule on the issue of whether there exists a constitutional right to treatment were brought before this Court. In each case, certiorari was denied. People ex rel Anonymous v. LaBurt, 385 U.S. 936 (1966); United States ex rel Stephens v. LaBurt, 373 U.S. 928 (1963); People ex rel Anonymous v. LaBurt, 369 U.S. 428 (1962).

This suit was initiated in the District Court for the Northern District of Florida prior to Donaldson's release on July 31, 1971. The initial complaint was styled a class action on behalf of all patients in Department C of the Hospital. In addition to damages, for Donaldson and the class, the complaint sought habeas corpus relief as to Donaldson and the class, and injunctive relief requiring the hospital to provide adequate treatment. After Donaldson's release, the District Court dismissed the case as to the class action allegations, and the first amended complaint was filed on August 30, 1971. The amended complaint

sought individual damages and renewed Donaldson's prayers for declaratory and injunctive relief to restrain the enforcement of Florida's civil commitment statutes unless Florida provided adequate treatment to its civilly committed mental patients. Jurisdiction was alleged pursuant to 42 U.S.C. §1983, 28 U.S.C. §1343(3), and 28 U.S.C. §§ 2281, 2284. The amended complaint also asked the district court to convene a three-judge court to consider the plaintiff's attack on the constitutionality of the civil commitment statutes as they then operated. On November 30, however, the plaintiff in a memorandum brief, abandoned the prayer that a three-judge court be convened. The prayers for injunctive and declaratory relief were eliminated from the case.

The key allegation in the amended complaint charged that the defendants O'Connor and Walls had "acted in bad faith toward Plaintiff and with intentional, malicious, and reckless disregard of his constitutional rights." The complaint alleged examples of such actions, including the denial to Donaldson of grounds privileges; the refusal of the psychiatrists to speak with him, even at his own request; refusal or obstruction of his opportunities for out-of-state discharge, despite a recommendation by a staff conference that he be given such a discharge, and despite the presentation of a signed parental consent to such a discharge. The core of the charge, however, was that Walls and O'Connor acted intentionally and maliciously in "confining Donaldson

against his will, knowing that [he] was not physically dangerous to himself or others"; in confining him "knowing that [he] was not receiving adequate treatment, and knowing that absent such treatment the period of his hospitalization would be prolonged"; and that they "intentionally limit[ed] [his] 'treatment' program to 'custodial care' for the greater part of his hospitalization." Corresponding to these allegations, the complaint sought $100,000 damages against Walls and O'Connor.

The trial began November 21, 1972, and continued for four days. The jury returned a verdict awarding Donaldson $17,000 in compensatory damages and $5,000 in punitive damages against O'Connor, and $11,500 in compensatory damages and $5,000 in punitive damages against Gumanis. The jury returned verdicts in favor of the other three defendants. From the judgment entered on that verdict, Gumanis and O'Connor separately appealed to the United States Court of Appeals for the Fifth Circuit. The Judgment of the District Court was affirmed on April 26, 1974. Appellant Gumanis filed a timely Motion for Rehearing which had not been ruled on by the Court as of the time this Petition was filed.

Reasons for Granting the Writ

I

CERTIORARI SHOULD BE GRANTED TO DECIDE WHETHER THERE IS A CONSTITUTIONAL RIGHT TO TREATMENT FOR PERSONS INVOLUNTARILY COMMITTED TO STATE MENTAL HOSPITALS.

The Court of Appeals held that a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition. The Court of Appeals found that civil commitment entails a "massive curtailment of liberty" in the constitutional sense, citing Humphrey v. Cady, 405 U.S. 504 (1972), and noted that the due process clause of the Fourteenth Amendment to the United States Constitution guarantees a right to treatment upon a two-part theory.

The first part of the theory is concerned with the rationale for confinement. In its discussion, the Court of Appeals noted that three distinct grounds are recognized by state statutes: danger to self; danger to others; and need for treatment, or for "care," "custody," or "supervision." The Court placed these grounds into two categories; one a "police power" rationale for confinement, the other a "parens patriae"

rationale. Danger to others was considered a "police power" rationale; need for care or treatment a "parens patriae" rationale; and danger to self as an area combining elements of both. The Court reasoned that where, as in Donaldson's case, the basis for confinement evokes the parens patriae rationale, that the patient is in need of treatment, the due process clause requires that the deprivation of liberty brought on by commitment be accompanied by treatment. It was this theory the Court applied in this case although there was considerable evidence that numerous physicians felt Donaldson was dangerous to himself and others, which would bring elements of the police power rationale into consideration.

The second part of the theory is concerned with the traditional limitations on a government's right to confine -- that confinement be in retribution for a specific offense; that it be limited to a fixed term; and that it follow a proceeding where fundamental due process safeguards are present. Ignoring the due process protections inherent in the initial commitment hearing, the Court of Appeals found that where such limitations are absent, such as in an involuntary civil commitment to a state mental hospital, there must be a quid pro quo extended by the government to justify confinement. The Court then noted that the quid pro quo most commonly recognized is the provision of rehabilitative treatment.

A discussion of whether there exists a constitutional right to treatment requires a brief examination of the historical basis for involuntary hospitalization of the mentally ill.

In 1603, Lord Coke described the law of insanity as it had developed in England and discussed the Statute de Praerogation Regis, which explicated the King's authority over the property of the mentally ill and outlined the King's duty to care for them in Beverly's Case, 4 Co.Rep. 123(b), 76 Eng.Rep. 1118 (K.D. 1603). Later, during the Eighteenth century, confinement was a privilege reserved for the more affluent. According to Blackstone, one applied for confinement when the disorder was regarded as permanent and the individual could afford the cost of such confinement.[2]

During the Colonial period in the United States, families were expected to care for the mentally ill. In the absence of family the colonial community would not provide care, but would attempt to send the individual back to where he or she came from. In Governor Winthrop's Journal, it is reported that on December 11, 1634, "[o]ne Abigail Gifford, sent by ship into this ccuntry, and being found to be somewhat distracted, and a very burdensome woman, the governor

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[2] 1 W. Blackstone, Commentaries, 303-07 (9th ed. 1783); 2 F. Pollack & F. Maitland, The History of English Law (2nd ed. 1911).

returned her back by warrant to the same parrish, in the ship Rebecca."[3] Some years later, the Massachusetts Bay Company enacted legislation for the detention of violent persons so "that they do not damnify others,"[4] the rationale being that if the individual was a threat to the community, the community could act accordingly.

The emergence of the idea of danger within the purview of organized medicine appears to have been accomplished in 1769 when the first institution for the insane was opened at Williamsburg, Virginia. The chartering act made specific reference to the need for restraining those "who may be dangerous to society."[5] The community's role in providing for the violent and insane who could not be maintained properly by their families was clearly established at that early time. The emphasis

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[3] I Winthrop's Journal, p. 144, Reprinted in the History of New England 1630-1649, by the Massachusetts Historical Society.

[4] 5 Records of the Governor and Company of the Massachusetts Bay in New England 80 (1854).

[5] A. Miles, An Introduction to Public Welfare 79 (1949).

remained on detention, rather than treatment.

Detention was apparently rarely challenged in the early days of our nation. One of the first cases was brought in 1845 when Josiah Oakes petitioned the Massachusetts Supreme Court by writ of habeas corpus to determine the legality of his confinement. In re Josiah Oakes, 8 L.Rep. 123 (1845-46). Although the attending physician could not predict with any degree of certainty that Oakes would indeed engage in a dangerous act were he not confined, the Court relied on the possibility of danger as a decisive factor against him. The Court ruled that restraint was permissible because "the right to restrain an insane person of his liberty is found in that great law of humanity, which makes it necessary to confine those who goings at large would be dangerous to themselves and others." The Court further states:

> The necessity which creates the law, creates the limitations of the law. The question must then arise in each particular case, whether a patient's own safety or that of others requires that he should be maintained for a certain time, and whether restraint is necessary for his restoration or will be conducive thereto. The restraint can continue as long as the necessity continues. That is the limitation and the proper limitation.

The basis of a state's right to confine mentally ill persons against their will rests upon the dual reasons of (1) the power of the state in its role of parens patriae, and (2) its duty to protect under the police power.[6] A state has an obvious interest in the safety of all citizens and the maintenance of a healthy and productive citizenry. It might be argued that the parens patriae theory alone cannot justify confinement without benefit to or treatment of the individual,[7] but it cannot be reasonably or responsibly argued that society does not have the right to confine mentally ill persons with a propensity for dangerous behavior, with or without accompanying treatment.

Treatment, as a goal of confinement of mentally ill persons, emerged with the development of psychiatry as a medical specialty and the successful development of drug and shock therapy during the first half of this century. At this point, the states began to provide such care as was possible within the limitations of state resources.[8]

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6 Ross, Commitment of the Mentally Ill: Problems of Law and Policy, 57 Mich.L.Rev. 945 (1959).

Note, Civil Commitment of the Mentally Ill: Theories and Procedures, 79 Harv.L. Rev. 1288 (1966).

7 Note, The Nascent Right & Treatment, 53 Va.L.Rev. 1134 (1967).

8 G. Zolborg, A History of Medical Psychology (1941).

The idea that there exists a constitutional right to treatment for the involuntarily committed mental patient was first announced in 1960 in an editorial[9] in the American Bar Association Journal. The editorial had as its impetus an article of Dr. Morton Birnbaum, of the New York Bar, appearing in the same issue.[10]

In his initial article, Dr. Birnbaum suggested the need for recognition of a right to treatment and based his suggestion on the realization that care in state mental hospitals is often substandard. Dr. Birnbaum recognized that inadequate treatment does not often result from individual action by the medical staff, but from inadequate legislative funding:

> As the law has not recognized this right, the state can, and generally does, compel the public mental institution to give inadequate medical treatment to its inmates. The state does this: (A) by compelling the institutionalization of those persons whom it considers to be sufficiently mentally ill to require institutionalization for care and treatment;

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9 Editorial, A New Right, 46 A.B.A.J. 516 (1960).

10 Birnbaum, The Right to Treatment, 46 A.B.A.J. 499 (1960).

> and, (B) by not appropriating sufficient funds to enable the public mental institution to obtain the number of competent personnel and to maintain the adequate physical plant that is necessary to provide therapeutic, rather than custodial, care for these sick people.
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> * * *
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> In too many cases, the efficacy of modern medicine is dependent upon a legislative decision rather than upon medical knowledge. If the legislature appropriates sufficient funds to enable the public mental institution to provide proper medical care, the effect of institutionalization is decided to a great extent by the limitations of medical knowledge. If the legislature appropriates insufficient funds, the effect of institutionalization is decided to a great extent by legislative fiat.

The article further suggests that assuming recognition of a right to treatment, that the proper form of remedy would be release, pursuant to habeas corpus proceedings, for those receiving inadequate care. It was thought that the prospect of wide-scale release of mentally ill persons would force the states to either provide adequate care or abandon public mental health institutions altogether. Dr.

Birnbaum noted the obvious threat to the health and welfare of the general citizenry and patients, but felt that such action was justified by the eventual improvement of public institutions.

At the conclusion of his article, Dr. Birnbaum noted several problems with the recognition and enforcement of a right to treatment. The most important of these was the practical realization that in order to avoid the problem of wide-scale release of mentally ill persons and other injustices, that the courts should provide a reasonable interim period between recognition of the right and enforcement of the right.

There is no judicial recognition of a constitutional right to treatment for several years following Dr. Birnbaum's suggestion of such a right. In 1966, the Court of Appeals for the District of Columbia held in Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966), that a patient committed involuntarily to a mental hospital under a District of Columbia Statute had a statutory right to treatment pursuant to the District of Columbia 1964 Hospitalization of the Mentally Ill Act.[11] In addition, Judge Bazelon, writing for the majority, stated that, even absent such a statute, forced confinement in a public mental hospital without treatment might violate either the

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11 D. C. Code Ann. §21-562 (1967).

due process clause, the equal protection clause, or the Eighth Amendment. Since the decision in Rouse v. Cameron, supra, two District Courts have held that there is a right to treatment for civilly committed mentally ill persons.[12] A third District Court has completely rejected the theory as unworkable.[13] A fourth case has recently extended a right to treatment to civilly committed mentally retarded persons.[14]

However attractive the theory of a right to psychiatric treatment may be to all persons concerned with the preservation of individual liberties,

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12 Stachulak v. Coughlin, 364 F.Supp. 686 (N.D.Ill. 1973); Wyatt v. Stickney, 325 F.Supp. 781 (M.D.Ala. 1971), on submission of proposed standards, 334 F.Supp. 1341, enforced, 344 F.Supp. 373, 387, Appeal docketed sub non, Wyatt v. Aderhold, No. 72-2634 (5th Cir. 8/1/73).

13 Burnham v. Department of Public Health, 349 F.Supp. 1335 (N.D.Ga. 1972), appeal docket, No. 72-3110 (5th Cir. 10/4/72).

14 Welsch v. Likins, 373 F.Supp. 487 (D.Minn. 1974).

serious problems arise from the attempted application and enforcement of such a right. These problems are of both a legal and medical nature and have been the subject of considerable commentary.[15]

The overriding problem in defining and applying a right to treatment lies in the problem of judges and juries untrained in medicine and the highly specialized field of psychiatry attempting to second guess the judgment of trained physicians and psychologists concerning what constitutes "adequate treatment."

As early as 1942, over forty (40) distinct methods of psychotherapy were accepted by the medical profession.[16] These methods listed by Levine range from active physical treatment such as

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15 Szasz, The Right to Psychiatric Treatment: Rhetoric and Reality, 57 Geo.L.J. 740 (1969); Cameron, Non-Medical Judgment of Medical Matters, 57 Geo.L.J. 716 (1969); Note, Guaranteeing Treatment for the Committed Mental Patient: The Troubled Enforcement of an Elusive Right, 32 Md.L.Rev. 42 (1972); Katz, The Right to Treatment--An Enchanting Legal Fiction, 36 U. of Chi. L.R. 755 (1969).

16 M. Levine, Psychotherapy in Medical Practice, 17-19 (1942). 1-4, Current Psychiatric Therapies (J. Masserman ed. 1961-64).

"shock therapy" to more subtle forms of therapy such as ignoring certain symptoms and attitudes. Dr. Thomas S. Szasz observes the difficulties involved in presently defining what constitutes "illness," "treatment," and "patient" without confusing injection of an indefinable right to treatment.[17] As Dr. Szasz points out that it is extremely difficult to determine not only whether certain behavior constitutes "illness" but to determine what constitutes the best method of treatment or whether the chosen treatment is "adequate."

Dr. Szasz believes that what is termed a "right" to treatment should be labelled a "claim" for treatment and points out that a "right" to treatment for the patients would seriously impair a physician's prerogatives of choosing his patients and methods of treatment. This conflict is heightened in a state mental hospital where a physician cannot choose his patients.

The impossibilities of judicial definition and application of a right to treatment were discussed by now Chief Justice Burger in Lake v. Cameron, 124 U.S.App.D.C. 264, 364 F.2d 657, 663 (1966):

> ...this Court now orders the District Court to perform functions

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17 Szasz, The Right to Health, 57 Geo. L.J. 734, 741, 743.

normally reserved to social agencies by commanding search for a judicially approved course of treatment or custodial care for this mentally ill person who is plainly unable to care for herself. Neither this Court nor the District Court is equipped to carry out the broad geriatric inquiry proposed or to resolve the social and economic issued involved.

It has been strenuously argued in this and preceding cases that expert testimony is sufficient to guide a judge or jury to a proper determination as to what constitutes proper and adequate treatment in any specific case. The Court of Appeals accepted and applied that theroy in this case. While the testimony of experts and guidelines formulated by professional associations may be helpful in determining the adequacy of care provided by an entire hospital or system such as in an inquiry as in Wyatt v. Stickney, 325 F.Supp. 781, 784 (M.D.Ala. 1971), 344 F.Supp. 373, 375-376 (M.D.Ala. 1972), it cannot be easily applied to an individual patient. To attempt such application is to subject the professional judgment and decisions of a trained physician to the scrutiny of untrained laymen. It is common knowledge that any two physicians rarely treat any individual in the identical manner. One physician may consider some form of active treatment essential while another may choose to treat the symptoms by ignoring them.

A graphic illustration of a court faced with two widely divergent expert views on proper treatment, raised in the context of incompetence to stand trial, is provided in United States v. Klein, 325 F.2d 283, 286 (2nd Cir. 1963), wherein the Court lamented:

> Mental disorders being what they are, it is not surprising that eminent psychiatrists differ as to methods of treatment. Here Dr. Shoefield believed Klein would respond to a more psychoanalytic form of therapy; Dr. Douglas, by his own testimony, favored a more physiological approach. Courts of law, unschooled in the intricacies of what may be the most perplexing of medical sciences, are ill-equipped to choose among such divergent but responsible views. In a case like this, where a man's life may literally hang in the balance, a judge ought not undertake the hazardous venture of changing the course of psychiatric treatment without, at the least, a much fuller hearing and a greater preponderance of expert testimony than existed here.

Advocates of the right to treatment tend to ignore the difficulties of laymen sitting in judgment of the decisions of trained physicians with the argument that any judge who can allocate AM radio frequencies to avoid electronic interference is capable of

determining, with the aid of experts, which manner of treatment is "adequate" or "proper."[18] This Court recognized the dilemma in Greenwood v. United States, 350 U.S. 366 (1956), wherein Justice Frankfurter noted the transiency of psychiatry when reviewing the testimony of two psychiatrists, declaring:

> ...their testimony illustrates the uncertainty of diagnosis in this field and the tentativeness of professional judgment. The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment...

This argument ignores the difference between the more exact science of electronics and the vague, fluid theories of psychotherapy. While it may be possible to determine whether one radio station will interfere with another with some degree of certainty, it has been demonstrated above that it cannot be said with equal certainty that one method of treatment is superior to another in any particular case.

Following the decision in Rouse v. Cameron, the American Psychiatric

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[18] Bazelon, Implementing the Right to Treatment, 36 U.Chi.L.Rev. 742 (1969).

Association released a policy statement on the adequacy of treatment.[19]

The A.P.A. statement contends that "[t]he definition of treatment and the appraisal of its adequacy are matters for medical determination," but sets forth seven considerations relevant to a determination of whether a patient is receiving adequate care: (1) The purpose of hospitalization, and differences between long-term and short-term treatment programs; (2) the degree to which treatment is changed as diagnosis develops during institutionalization; (3) the need to protect the patient from self-inflicted harm; (4) the importance of interrupting the disease process, as in separating the psychotic from his family stress situation; (5) the effective use of physical therapies; (6) efforts to change the emotional climate around the patient meaning "mileau therapy" and related measures; and (7) the availability of conventional psychological therapies.[20] The statement strongly stresses the importance of considering the limitations of the staff and facilities at hand, and the absolute need for cooperation by the patient in his treatment program.[21]

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19 American Psychiatric Association, A Position Statement in the Question of Treatment, 123 Am. J. Psychiatry, 1458 (1967).

20 Id. at 1458-1459.

21 Id. at 1459-1460.

It has been suggested that it is no more difficult for a judge or jury to determine whether a patient has received "adequate" treatment than to hear a traditional medical malpractice case.[22] However, the analogy is not accurate. Physical medicine has a relative certainty compared with psychotherapy, both in diagnosis and in the efficacy of particular treatments. In the psychiatric malpractice field, the courts have exhibited extreme reluctance to examine issues of treatment and great confusion in trying to decide when negligence has occurred. Most of the cases involve such matters as discharge or failure to prevent escape from an institution, not the superiority of one form of treatment or therapy over another.[23] When a patient sues the doctor or hospital for negligent treatment, as in shock therapy injury cases, there is no comparison of treatments, but rather an examination of how the particular treatment was administered.[24]

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[22] Rouse v. Cameron, 373 F.2d at 457, n. 30.

[23] J. Katz, J. Goldstein, & J. Dershowitz, Psychoanalysis, Psychiatry, and Law, 728-751 (1967).

[24] CF. Hammer v. Rosen, 7 App.Div. 2d 216, 181 N.Y. S. 2d 805 (1959).

Negligence, a traditional guiding point for courts and juries in medical malpractice litigation, will be missing from federal cases seeking to enforce a constitutional right to treatment because negligence cannot form the basis of jurisdiction under the Civil Rights Acts. Smith v. Clapp, 436 F.2d 590 (3rd Cir. 1970); Isenberg v. Prasse, 433 F.2d 449 (3rd Cir. 1970).

The difficulties of one District Judge in attempting to define and apply a right to treatment are described in Burnham v. Department of Public Health, 349 F.Supp. 1335 (N.D.Ga. 1972), wherein Chief Judge Smith explored the requirements of civil rights jurisdiction, the nature of the asserted right to treatment, and the impossibilities of its definition and responsible application. Judge Smith concluded that there exists no affirmative federal constitutional right to treatment. Recent commentary recommends the approach taken in Burnham.[25] Professor Reisner notes that while objective standards might be judicially developed to be applied to institutions as a whole, he concludes that judicial attempts to gauge the appropriateness of treatment offered to individual patients cannot help but encounter the difficulties foreseen by the Burnham court.[26]

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25 Reisner, Psychiatric Hospitalization and the Constitution: Some Observation on Emerging Trends.

26 Id.

The Court of Appeals for the Fifth Circuit brushed aside objections that courts are incapable of determining what constitutes "adequate" treatment with the view that since other courts had attempted to do so, it must be that the judiciary is perfectly capable of sitting in judgment of the professional decisions of trained physicians. The Court also noted that there were cases, declaring the case at bar to be one, where the jury could determine whether a patient has been denied his "rights" by comparing the care he received under one physician to that he received under another. Both theories place laymen in the shoes of psychiatrists and the latter does not, as the Court of Appeals suggests, avoid the determination of which treatment or therapy is "adequate" or "proper" in any particular case.

The Court of Appeals argued further that a jury would be justified in finding a denial of "rights" by concluding that the defendants below obstructed the release of a patient even though they knew he was not receiving treatment. This theory ignores the fact that physicians in a state mental hospital are required to accept all patients committed to their care and are not empowered to release a patient until he is "cured." Even though a doctor may realize that a patient is not receiving treatment, or does not benefit from the available treatment, due to lack of available

staff, facilities, operating funds or other reasons, a doctor in a state institution simply lacks the statutory authority to release a mentally ill patient.

The Court of Appeals held that a quid pro quo, in the form of adequate treatment, must be advanced by the state in exchange for the liberty of the involuntarily committed mental patient. This theory ignores the realities providing the basic justification for involuntary confinement of the mentally ill. Involuntary commitment rests upon two interrelated foundations: (1) the "police power" of the state; and (2) the state's role as "parens patriae". The two are not easily separated in this setting. Basically, when the state provides mental health facilities for its citizens it acts in parens patriae. When the state involuntarily commits a citizen to a state mental health institution, it acts pursuant to its traditional police powers to protect the general public. A state has a strong interest in a healthy, productive, educated society.[27] Accordingly, for the benefit and protection of society, the state provides for state custody and maintenance of incompetent persons. The

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27 Penn Dairies v. Milk Control Commission, 318 U.S. 261 (1943).

28 Prince v. Massachusetts, 321 U.S. 158 (1944).

29 Jacobson v. Massachusetts, 197 U.S. 11 (1905).

state undertakes to care for those persons whose mental illness makes it difficult or impossible for them to care for themselves or to be cared for by their families, until such time as the patient is considered well enough to return to society. The state does that and nothing more.

The nature of treatment supplied beyond custodial care is a question for the states, not the federal courts. Whether a state shall provide a particular governmental service, and if so in what amount (qualitatively and quantitatively) are generally questions for the states and do not raise federal constitutional issues cognizable under 42 U.S.C. §1983, the Civil Rights Act of 1871, and 28 U.S.C. §1343(3).[30] It must be remembered that not every governmental function implies a corresponding right or "quid pro quo" as it has been termed by the Court of Appeals. Collins v. Hardyman, 341 U.S. 651 (1951); Niklaus v. Simmons, 196 F.Supp. 691 (D.Neb. 1961).

An analogous situation might be that of the public schools. School attendance is compulsory so it might be argued that there must, therefore, be a constitutional right to an adequate education as the

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30 Fullington v. Shea, 320 F.Supp. 500 (D.Colo. 1970), affirmed 404 U.S. 963 (1970). CF. McGowan v. Maryland, 366 U.S. 420 (1961).

quid pro quo to those persons forced to attend school. Definition of such a right might be equally incapable of accurate definition. However, the quid pro quo theory has not been extended to the public schools. There is no right to an education even though attendance is involuntarily compelled.[31]

It was admitted by Respondent, in the pleadings, that there is no statutory right to treatment in Florida, as in the District of Columbia statute before the court in Rouse v. Cameron. Petitioner further believes, that there can be no federal constitutional right to treatment, as demonstrated above. Petitioner has shown that aside from the problem of determining what constitutes mental illness, that there is a bewildering array of accepted methods of therapy and a wide divergence of opinion between respected experts as to which method may be proper in a particular case. A right must be capable of definition. The proposed right of treatment defies definition; its application and enforcement are impossible in the absence of a definition.

This Court should grant certiorari to resolve the issue of whether there exists a constitutional right to treatment for persons involuntarily committed to a state mental hospital. This case presents the first opportunity for this Court to examine the issue presented, resolve

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[31] Fleming v. Adams, 377 F.2d 975, 977, (10th Cir. 1967), cert. den. 389 U.S. 898 (1967).

the issue of whether such a right exists, and, in so doing, provide necessary guidance for state administrators, patients, physicians and the lower federal courts.

II

CERTIORARI SHOULD BE GRANTED TO REVIEW THE HOLDING OF THE COURT OF APPEALS THAT, ASSUMING THE EXISTENCE OF A RIGHT TO ADEQUATE TREATMENT, ATTENDING PHYSICIANS AT A STATE MENTAL HOSPITAL MAY BE HELD PERSONALLY LIABLE, IN THE ABSENCE OF BAD-FAITH OR MALICE, FOR A DEPRIVATION OF THAT RIGHT.

The Court of Appeals for the Fifth Circuit held that the Petitioner and Dr. Gumanis, the other Appellant below, could properly be held personally liable for an alleged deprivation of the right to treatment.

Petitioner submits that a doctor in a state mental hospital should not be held personally liable for the deprivation of a constitutional right, whose existence and enforcement could not have been reasonably foreseen. Furthermore, doctors in a state hospital should not be held liable for deprivation of a constitutional right to adequate treatment, when they have no control over the number or nature of the patients they must treat, the facilities and resources available to them, or the statutory right to either refuse to treat a particular patient

or release a patient before he is restored to his mental health. The Court of Appeals found such considerations without merit.

It has been known for many years that state mental hospitals are woefully inadequate in terms of physical facilities, staff, and financing.[32] State mental hospitals are a creature and occasional victim of legislative fiat. They exist and operate on the funds made available by the legislature, and have only as many staff members as allowed by the annual appropriations bill. The administrator and staff have no meaningful control over the facilities and resources at their disposal. Likewise, they must accept every patient sent to them under a valid commitment order. They are not statutorily empowered to refuse any patient committed for care or discharge any patient who has not regained his mental health.

Against that set of facts, the Court of Appeals found that a doctor in a

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32 Birnbaum, Some Remarks on the Right to Treatment, 23 Ala.L.Rev. 623 (1971); Birnbaum, A Rationale for the Right, 57 Geo. L.J. 752 (1969); Birnbaum, The Right to Treatment, 46 A.B.A.J. 499 (1960); Editorial, A New Right, 46 A.B.A.J. 516 (1960).

state institution using the limited resources available to him, could be held personally liable for failing to give adequate treatment, as determined by a court.

If the situation were not as serious as it is, it would be ludicrous to imagine a federal court finding that an over-worked, under-paid, staff psychiatrist in an over-crowded state hospital, working with a patient-staff ratio averaging five hundred patients per physician, using the meager facilities available to him, could be held personally liable in the amount of $23,000, to a former patient, for failing to foresee the existence of a previously unestablished constitutional right and failing to provide each and every patient with "adequate treatment", as determined by a group of laymen.

The controversy in this case centers around the effort to establish a right to treatment and demonstrate that Kenneth Donaldson was denied that right. The inequity arises when the right, if established, is applied retroactively to create monetary liability on the part of Petitioner and Dr. Gumanis. In essence, their wrongful acts, if any, consisted of the violation of a prospective right, assuming the present existence of a right to treatment. Justice Holmes once defined a prospective right as follows:

> A prospective right is not yet a right. It is only an expectation having certain intensity of

reasonableness.[33]

The extreme difficulty of predicting the emergence of a new right or change in the law has been judicially recognized with increasing frequency in the past few years. Certainly, state officers and employees are not entitled to the absolute immunity accorded the judiciary, because that would frustrate the intent of Title 42 U.S.C. §1983. However, this Court has found that there is limited immunity for acts done in good faith by state officers, within the scope of their official duties.[34]

State employees and administrators should be required to act as reasonable and responsible men, but "they neither can nor should be expected to be seers in the crystal ball of constitutional doctrine. They are not charged with predicting the future course of constitutional law."[35] The Court of Appeals

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[33] Southern Pacific R. R. Co. v. United States, 189 U.S. 447, 450 (1903).

[34] Pierson v. Ray, 386 U.S. 547, 555-557 (1967).

[35] Westberry v. Fisher, 309 F.Supp. 12 (D.Me. 1970); See also: Eslinger v. Thomas 476 F.2d 225 (4th Cir. 1973); Taylor v. Perini, 365 F.Supp. 557 (N.D.Ohio 1972); Skinner v. Spellman, 480 F.2d 539 (4th Cir. 1973); Collins v. Schoonfield, 363 F.Supp. 1152 (D.Md. 1973); McKinney v. DeBord, 324 F.Supp. 928 (E.D.Cal. 1970).

for the Fifth Circuit noted that it was in conflict with the Ninth Circuit in Hoffman v. Halden, 268 F.2d 280 (9th Cir. 1959), but felt that the Hoffman rule was in error. The Court of Appeals believed that in the absence of such immunity, the District Judge's instruction to the jury on the good faith defense alone was sufficient.

Petitioner submits that he should be immune from damages in a situation where he was acting in good faith, according to accepted institutional policy and procedures, and could not reasonably be expected to foresee the future emergence and enforcement of a constitutional right to treatment. State employees should not be exposed to personal monetary liability for acts subsequently condemned as unconstitutional by the recognition of a new constitutional right.[36]

This Court should grant certiorari to determine whether it is proper for state-employed physicians at state mental hospitals to be held personally liable for deprivation of the proposed right to treatment even though such doctors have no control over the number of patients they must treat or the quality and quantity of treatment facilities available to them. So, too, the Court should grant certiorari to resolve the apparent conflict between the Court of Appeals for the Fifth Circuit

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36 Pierson v. Ray, supra, note 34.

and other Courts of Appeal on the issue of whether state employees and officers may be held personally liable for past actions, made in good faith, subsequently declared unconstitutional by the recognition of a new constitutional right.

III

CERTIORARI SHOULD BE GRANTED TO DETERMINE WHETHER, ASSUMING THERE IS A CONSTITUTIONAL RIGHT TO TREATMENT, THE RESPONDENT WAIVED THAT RIGHT.

In its opinion, the Court of Appeals for the Fifth Circuit noted that the Respondent, Donaldson, a Christian Scientist, refused to submit to either medication or shock therapy during his confinement at Florida State Hospital. The Court mentioned that recreational therapy, religious therapy and mileau therapy were substituted, but promptly dismissed all three forms of therapy as, in the opinion of the Court, inadequate. The Court emphasized their displeasure with "mileau therapy" citing a law review article, written by an attorney, as support for the notion that "mileau therapy" is an excuse used by psychiatrists to cover up a lack of adequate treatment.[37]

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[37] Halpern, A Practicing Lawyer Views the Right to Treatment, 57 Geo.L.J. 782, 786-787, n. 19 (1969).

Articles by physicians and psychiatrists take the opposite view that "mileau therapy" is often an excellent alternative or companion to medical or shock therapy.[38]

Assuming arguendo that there exists a constitutional right to treatment, is there a corresponding right to refuse treatment? Commentators suggest that a right to refuse treatment may be a necessary adjunct to the proposed right to treatment.[39] Statutes in Alaska and California expressly recognize a right to refuse on religious and other grounds.[40]

A natural question arises as to whether persons committed for reasons related to mental competency should be considered competent to consent to, or refuse offered treatment. California and Alaska statutes grant the

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[38] Cameron, Nonmedical Judgment of Medical Matters, 57 Geo.L.J. 716 (1969); J. Frank, Persuasion and Healing--A Comparative Study of Psychotherapy (1961).

[39] Miller, Dawson, Dix and Parnas, Cases and Materials on Criminal Justice Administration and Related Processes - The Mental Health Process, 1663 (1971).

[40] §7104, California Wel. & Inst. Code, (1969 Supp.); §47.30.130, Alaska Statutes, (1969 Supp.).

patient the right to decide so long as the administrators determine that he is in such a "condition of mind as to render him competent to make the decision."[41] Law review proponents of a right to treatment generally refuse, in their zealous protection of the patient's right to treatment, to recognize the right of a patient to refuse treatment.[42] Some suggest that a right to treatment imposes a duty to be treated.[43] Justice Holmes supported that view stating:

> While there are in some cases legal duties without a corresponding right; we never see a legal right without either a corresponding duty or compulsion stronger than duty.[44]

Whether there is a right to refuse treatment or a duty to be treated, the evidence in this case demonstrates

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41 §7104 California Wel. & Inst. Code.

42 Halpen, A Practicing Lawyer Views the Right to Treatment, 57 Geo.L.J. 782, 801 (1969); Note, The Nascent Right to Treatment, 53 Va.L.Rev. 1134, 1140 (1967).

43 Katz, The Right to Treatment--An Enchanting Legal Fiction?, 36 U. of Chi. L.R. 755 (1969).

44 Holmes, Uncollected Letters, 66. See also: Ogden v. Saunders, 12 Wheat. 213, 281-82 (1827).

conclusively that either Donaldson exercised his right not to be treated or he utterly failed in his duty to be treated. The record is replete with evidence that he not only continually refused medicine and shock therapy, but that he refused, at times, to participate in occupational and group therapies. The Court in Rouse v. Cameron suggested that patient refusal to cooperate in therapy does not excuse lack of adequate treatment, but rather is a further indictment of the treatment facilities and staff. This attitude was prompted primarily by the requirements of the District of Columbia statute involved. However, the Court in Wyatt v. Stickney suggested that the same attitude should apply to the constitutional right to treatment. The Wyatt standard ignores the patient who refuses treatment or is unamenable to treatment.[45]

While the courts and commentators do not believe patient cooperation is a key element of adequate treatment, the American Psychiatric Association believes patient cooperation is a necessity.[46]

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45 325 F.Supp. 781, 784 (M.D.Ala. 1971).

46 American Psychiatric Association, Position Statement on the Question of Adequacy of Treatment, 123 Am.J.Psychiatry 1458 (1967).

Donaldson, having continued to refuse numerous types of treatment, including shock treatment which had apparently been a successful element of his New York treatment, should not have been heard to complain of the "inadequacy" of his treatment. Therefore, even assuming the existence of a right to treatment, Donaldson could not present a valid claim. His actions should have been construed as an effective waiver or repudiation of any right to treatment. He failed to uphold his corresponding duty to be treated.

Certiorari should be granted to resolve the issue of whether, assuming the existence of a constitutional right to treatment, the Respondent, Donaldson, by his actions, effectively waived his right to treatment.

Conclusion

For the aforesaid reasons, it is respectfully prayed that a writ of certiorari be granted to review the judgment of the United States Court of Appeals for the Fifth Circuit.

Respectfully submitted,

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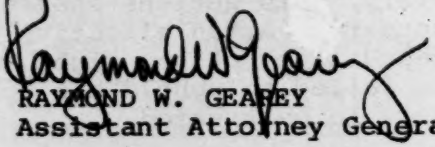

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Counsel for Petitioner.

July 25, 1974.

APPENDIX

Kenneth DONALDSON, Plaintiff-Appellee,

v.

J. B. O'CONNOR, M. D. and John Gumanis, M. D., Defendants-Appellants.

No. 73-1843.

RECEIVED
JUN 26 1974
ATTORNEY GENERAL'S OFFICE

United States Court of Appeals, Fifth Circuit.

April 26, 1974.

Former patient who had been involuntarily committed, under civil commitment procedures, to state mental hospital brought action against attending physicians and others for deprivation of alleged constitutional right to receive treatment or be released from the hospital. The United States District Court for the Northern District of Florida, David L. Middlebrooks, Jr., J., rendered judgment against the attending physicians and they appealed. The Court of Appeals, Wisdom, Circuit Judge, held that patient had constitutional right to such treatment as would help him to be cured or to improve his mental condition; that evidence supported finding that attending physicians had acted in bad faith with respect to their treatment of patient and were personally liable for his injuries or deprivations of his constitutional rights; and that limitation period did not begin to run until patient's release from the hospital.

Affirmed.

1. Appeal and Error ⇐233(2)

Defendants' objections to instructions given at plaintiff's request were properly before the court on review of judgment in favor of plaintiff even though defendants did not object to

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INDEXED

the instructions when they were discussed in chambers or after charge was read to jury where defendants did object to the instructions in a pretrial brief.

2. Constitutional Law ⇐255(5)

Where nondangerous patient is involuntarily committed under civil commitment procedures to state mental hospital, only constitutionally permissible purpose of confinement is to provide treatment and patient has due process right to such treatment as will help him to be cured or to improve his mental condition. U.S.C.A.Const. Amend. 14; 42 U.S.C.A. § 1983.

3. Constitutional Law ⇐255(1)

Generally, as matter of due process, long-term detention is permitted only when an individual is proved, in a proceeding subject to limitations of due process clause, to have committed a specific act defined as an offense against the state and such detention is allowed only for period of time explicitly fixed by sentence. U.S.C.A.Const. Amend. 14.

4. Constitutional Law ⇐255(1)

Where detention of individual is not in retribution for a specific offense, is not limited to fixed term and has not been preceded by proceeding in which fundamental procedural safeguards have been observed, there must be a quid pro quo, such as rehabilitative treatment or minimally adequate habilitation and care where rehabilitation is impossible, in order to justify confinement. U.S.C.A.Const. Amend. 14.

5. Civil Rights ⇐13.13(3)

In action by former mental patient who had been involuntarily committed under civil procedures to state mental hospital against attending physicians for deprivation of right to receive treatment or be released, evidence concerning withholding of treatment, blocking of efforts to have patient released, confinement of patient even though he was not dangerous or with reckless disregard as to whether he was dangerous and failure to do best that could have been done with available resources sustained determination that attend-

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ing physicians had acted in bad faith and were personally liable for injuries sustained by patient and for deprivation of patient's right to receive treatment. U.S.C.A.Const. Amend. 14; 42 U.S.C.A. § 1983.

6. Federal Civil Procedure ⇐2096

Objection to composition of jury was not timely raised where it was not mentioned until after jury was impanelled. 28 U.S.C.A. § 1863(b)(5).

7. Federal Civil Procedure ⇐2092

Jury selection plan allowing certain specified classes of persons, including actively engaged members of the clergy and actively practicing attorneys, physicians, dentists and nurses to be excused from jury duty if they desired was in compliance with Jury Selection and Service Act. 28 U.S.C.A. § 1863(b)(5); U.S.C.A.Const. Amend. 7.

8. Limitation of Actions ⇐58(1)

Limitation period applicable to civil rights action brought by former patient of state mental hospital against attending physician for deprivation of his right to receive treatment or be released did not begin to run until patient's release from hospital; period did not begin to run on date patient was taken from care of defendant physician. 42 U.S.C.A. § 1983; F.S.A. § 95.11(4), (5)(a), (6).

9. Limitation of Actions ⇐55(6)

When tort involves continuing injury, cause of action accrues and limitation period begins to run at time tortious conduct ceases.

10. Limitation of Actions ⇐55(6)

Cause of action for false imprisonment does not accrue until release of imprisoned party.

11. Courts ⇐375(4)

In a civil rights suit, even though state statute of limitation is applicable, question of when cause of action has accrued is a matter of federal rather than state law. 42 U.S.C.A. § 1983.

12. Civil Rights ⇐13.4(1)

Attending physician was not entitled to immunity from liability under Civil Rights Act for deprivation of right of patient at state mental hospital to receive treatment absent finding that he had acted in good faith. 42 U.S.C.A. § 1983.

13. Civil Rights ⇐13.8(1)

Full range of officials' immunities available at common law does not apply in actions brought under Civil Rights Act. 42 U.S.C.A. § 1983.

14. Civil Rights ⇐13.13(3)

Evidence that physicians who attended patient who had been involuntarily committed to state mental hospital had acted maliciously, wantonly or oppressively was sufficient to sustain award of punitive damages for deprivation of patient's right to receive treatment or be released. 42 U.S.C.A. § 1983.

15. Civil Rights ⇐13.10

Failure of patient who had been involuntarily committed to state mental hospital to petition for restoration of his competency did not preclude determination that attending physicians had deprived patient of his right to receive treatment or to be released where state law did not permit person adjudged incompetent to petition on his own for restoration of competency. F.S.A. § 394.22.

Appeals from the United States District Court for the Northern District of Florida.

Before RIVES, WISDOM and MORGAN, Circuit Judges.

WISDOM, Circuit Judge:

This case requires us to decide for the first time the far-reaching question whether the Fourteenth Amendment guarantees a right to treatment to persons involuntarily civilly committed to state mental hospitals. The plaintiff-appellee, Kenneth Donaldson, was civilly committed to the Florida State Hospital at Chattahootchee in January 1957, diagnosed as a "paranoid schizophrenic". He remained in that hospital

for the next fourteen and a half years. During that time he received little or no psychiatric care or treatment.

Donaldson contends that he had a constitutional right to receive treatment or to be released from the state hospital. In this action, filed February 24, 1971, he seeks damages under 42 U.S.C. § 1983 [1] against five hospital and state mental health officials who allegedly deprived him of this constitutional right.[2] A jury returned a verdict of $28,500 in compensatory damages, and $10,000 in punitive damages against the two defendants-appellants, Dr. J. B. O'Connor and Dr. John Gumanis. Dr. O'Connor, as Acting Clinical Director of the Hospital, was Donaldson's attending physician from the time of his admission until mid-1959. He was Clinical Director of the Hospital from mid-1959 until late 1963, and Superintendent thereafter until his retirement February 1, 1971. Dr. John Gumanis was Donaldson's attending physician from the fall of 1959 until the spring of 1967. He was added as a defendant by an amended complaint filed April 20, 1972. The jury returned a verdict in favor of the other three defendants.

Gumanis and O'Connor bring separate appeals to this Court. They challenge the sufficiency of the evidence to support the

1. 42 U.S.C. § 1983 provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

2. Except when the text clearly indicates otherwise, we use the term "defendants" in this opinion to refer to Dr. Gumanis and Dr. O'Connor, against whom judgments were rendered. The other three who were sued were: Dr. Francis G. Walls, who became Acting Superintendent of the Hospital when O'Connor retired from that position in February 1971, and who held that position for about four months; Dr. Milton J. Hirschberg, who became permanent Superintendent, succeeding O'Connor, in June 1971; and Emmett S. Roberts, Secretary of the Department of Health and Rehabilitative Services in Florida at the time Donaldson filed his First Amended Complaint August 30, 1971.

jury verdict[3] and they contend that the Constitution does not guarantee a right to treatment to mental patients involuntarily civilly committed. Both argue, therefore, that the trial judge erred in denying a motion to dismiss for failure to state a claim and in instructing the jury that civilly committed mental patients have a constitutional right to treatment. In addition, Gumanis raises a number of lesser issues. We hold that the Fourteenth Amendment guarantees involuntarily civilly committed mental patients a right to treatment, and that the evidence was sufficient to support the verdict. We also reject the numerous lesser contentions advanced by Gumanis. Accordingly, we affirm the judgment in Donaldson's favor.

I.

To put the legal issues in proper context as well as to discuss the defendants' challenge to the sufficiency of the evidence, it is essential to review the facts in unusual detail.

Donaldson was committed January 3, 1957, on the petition of his father and after a brief hearing before a county judge of Pinellas County, Florida. He was admitted to the Florida State Hospital twelve days later, and soon thereafter was diagnosed as a "paranoid schizophrenic". The committing judge told Donaldson that he was being sent to the hospital for "a few weeks" to "take some of this new medication", after which the judge said that he was certain that Donaldson would be "all right" and would "come back here". Donaldson was not released until July 31, 1971, after he had instituted this suit.

3. The defendants raised the question of the sufficiency of the evidence on a motion for directed verdict made at the close of the plaintiff's evidence, and renewed at the close of all evidence. The defendants apparently did not move for judgment notwithstanding the verdict after the verdict was returned, but they did move for a new trial. The first ground they asserted in their motion for new trial was that "[t]he verdict is contrary to the clear weight of the evidence, which evidence showed that Defendants reasonably believed in good faith that due to his mental illness and need of treatment Plaintiff was properly confined".

There is little dispute about the general nature of the conditions under which Donaldson was confined for almost fifteen years. Donaldson received no commonly accepted psychiatric treatment. Shortly after his first mental examination, Donaldson, a Christian Scientist, refused to take any medication or to submit to electroshock treatments, and he consistently refused to submit to either of these forms of therapy. No other therapy was offered. At trial, Gumanis mentioned "recreational" and "religious" therapy as forms of therapy given Donaldson; but this amounted to allowing Donaldson to attend church and to engage in recreational activities, privileges he probably would have been allowed in a prison. In the oral argument on appeal the appellants' counsel made much of what they called "milieu therapy", which they said was given Donaldson. This was nothing more than keeping Donaldson in a sheltered hospital "milieu" with other mental patients; the defendants did not refer to anything specific about the "milieu" that was in any special way therapeutic.[4] Donaldson was usually confined in a locked room, where, according to his testimony, there were about sixty beds, with little more room between beds than was necessary for a chair; his possessions were kept under the bed.

At night he was often wakened by some who had fits and by some "who would torment other patients, screaming and hollering". Then there was "the fear, always the fear you have in your heart, I suppose, when you go to sleep that maybe somebody would jump on you during the night". A

4. "Milieu therapy" is a frequent response by doctors and hospitals to claims by patients that they are receiving inadequate treatment. See Halpern, A Practicing Lawyer Views the Right to Treatment, 1969, 57 Geo.L.J. 782, 786-87, n. 19. Halpern discusses "milieu therapy" in discussing Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451, in which the District of Columbia Court of Appeals held that there was a statutory right to treatment. He notes that "milieu therapy" is an "amorphous and intangible" concept, "the easiest therapeutic claim for an institution to assert and the most difficult for a patient to refute", Halpern, *supra*, at 787 n. 19.

third of the patients in the ward were criminals. Indeed, Donaldson testified, "The entire operation of the ward was geared to criminal patients."[5]

5. Some of Donaldson's testimony relating the conditions under which he lived is worth quoting:

"Q. Now, in the buildings you lived in Department A, were those buildings locked?

A. Yes, sir.

Q. Were the wards you lived on locked?

A. Yes.

Q. Were there metal enclosures on the windows?

A. Yes, padlocks on each window.

Q. Approximately how many beds were there in the rooms where you slept?

A. Sixty some beds.

Q. How close together were they?

A. Some of the beds were touching, the sides touched, and others there was room enough to put a straight chair if we had had a chair.

Q. Did you have chairs in the room you were in?

A. There wasn't a chair in the room I was in.

Q. All right, was there an outside exercise yard for your department?

A. Yes, there was one period in particular when nobody went out for two years.

Q. Now, Mr. Donaldson, you were civilly committed. You had not been charged with any crime, is that right?

A. That is right.

Q. Were there criminal patients on your ward?

A. There were criminal patients on the ward.

Q. Approximately what percent of the population on your ward were criminals?

A. Looking back, roughly, I would say a third. I do not know the figures for the whole department.

Q. Let's just talk about your ward.

A. Okay, I would say about a third in the wards I was in.

Q. Now, did you sleep in the same rooms as the criminal patients?

A. Yes.

Q. Did you get up at the same time?

A. Yes.

Q. Did you eat the same food?

A. Yes.

Q. In the same dining room?

A. Yes.

Q. Did you wear the same clothes?

A. Yes. The entire operation of the wards I was on was geared to the criminal patients.

During his first ten years at the hospital, progress reports on his condition were irregularly entered at intervals averaging about one every two and a half months. During those first ten years, he requested grounds privileges and occupational therapy; his requests were denied. In short, he received only the kind of subsistence level custodial care he would have received in a prison, and perhaps less psychiatric treatment than a criminally committed inmate would have received.

At the time Donaldson was admitted to the hospital in 1957, O'Connor was Assistant Clinical Director of the hospital. As Assistant Clinical Director, he was in charge of the hospital's Department A, then the white male ward, where Donaldson was assigned upon his admission to the hospital. In that

Q. Let me ask you, were you treated any differently from the criminal patients?
A. I was treated worse than the criminal patients.
Q. In what sense were you treated worse?
A. The criminal patients got the attention of the doctors. Generally a doctor makes a report to the court every month.
Q. For the criminal?
A. On the criminal patients, and that would be a pretty heavy case load. It didn't give them time to see the ones who weren't criminal patients.
Q. Was there a place on the ward you had access to for keeping personal possessions?
A. No, not at that time.
Q. What did you do with your personal possessions?
A. I kept mine in a cedar box under the mattress of my bed.
Q. Was there a place in the wards where you could get some privacy?
A. No, not anytime in all of the years I was locked up.
Q. Were you able to get a good nights sleep?
A. No.
Q. Why not?
A. On all of the wards there was the same mixture of patients. There were some patients who had fits during the night. There were some patients who would torment other patients, screaming and hollering, and the fear, always the fear you have in your mind, I suppose, when you go to sleep that maybe somebody will jump on you during the night.
They never did, but you think about those things. It was a lunatic asylum.'

position, O'Connor was Donaldson's attending physician. At that time, Gumanis was a staff physician in Department A. On July 1, 1959, O'Connor became Clinical Director of the hospital, and in the fall of 1959, Gumanis was placed in charge of Department A, and became Donaldson's attending physician. O'Connor was promoted from the position of Clinical Director to the position of Superintendent July 30, 1963, and served as Superintendent until he retired February 1, 1971. Gumanis served as Donaldson's attending physician until April 18, 1967, when Donaldson was transferred to Department C, until that time the Negro male ward. After the transfer, Donaldson's attending physician was Dr. Israel Hanenson, the head of Department C until Dr. Hanenson's death in the fall of 1970. After that, until his release, Donaldson's attending physician was Dr. Jesus Rodriguez.

Donaldson brought this suit while he was still a patient at the hospital. In his original complaint, Donaldson sought to bring this suit as a class action on behalf of all patients in the hospital's Department C. In addition to damages, to the plaintiff and to the class, the complaint sought habeas corpus relief directing the release of Donaldson and of the entire class, and sought broad declaratory and injunctive relief requiring the hospital to provide adequate psychiatric treatment.

After Donaldson's release, and after the district court dismissed the action as a class suit, Donaldson, on August 30, 1971, filed his First Amended Complaint. This complaint sought individual damages and renewed Donaldson's prayers for declaratory and injunctive relief to restrain the enforcement of Florida's civil commitment statutes unless Florida provided adequate treatment to its civilly committed mental patients. The complaint asked the district court to convene a three-judge district court to consider the plaintiff's attack on the constitutionality of the civil commitment statutes as they then operated. On November 30 however, the plaintiff in a memorandum brief abandoned the prayer that a three-judge

court be convened. The prayers for injunctive and declaratory relief therefore were effectively eliminated from the case.

The key allegation in the amended complaint charged that the defendants O'Connor and Walls had "acted in bad faith toward plaintiff and with intentional, malicious, and reckless disregard of his constitutional rights". The complaint alleged examples of such actions, including the denial to Donaldson of grounds privileges; the refusal of the psychiatrists to speak with him, even at his own request; refusal or obstruction of his opportunities for out-of-state discharge, despite a recommendation by a staff conference that he be given such a discharge, and despite the presentation of a signed parental consent to such a discharge. The core of the charge, however, was that Walls and O'Connor acted intentionally and maliciously in "confining Donaldson against his will, knowing that [he] was not physically dangerous to himself or others"; in confining him "knowing that [he] was not receiving adequate treatment, and knowing that absent such treatment the period of his hospitalization would be prolonged"; and that they "intentionallly limit[ed] [his] 'treatment' program to 'custodial care' for the greater part of his hospitalization". Corresponding to these allegations, the complaint sought $100,000 damages against Walls and O'Connor.

The trial began November 21, 1972, and continued for four days. The jury returned a verdict awarding Donaldson $17,000 in compensatory damages and $5,000 in punitive damages against O'Connor, and $11,500 in compensatory damages and $5,000 in punitive damages against Gumanis. The jury returned verdicts in favor of the other three defendants. From the judgment entered on this verdict, Gumanis and O'Connor appeal.

The trial centered, of course, upon the conditions of Donaldson's confinement and upon the defendants' behavior toward Donaldson. On the record as a whole, there was ample

evidence to support the jury's reaching any or all of the conclusions set forth in the following subsections in Part I of this opinion.

A. *The defendants unjustifiably withheld from Donaldson specific forms of treatment.*

The evidence establishes that there were at least three forms of treatment the defendants withheld from Donaldson.

First, he was denied grounds privileges. Since the purpose of hospitalization is to restore the capacity for independent community living, one of the most basic modes of treatment is giving a patient an increasing degree of independence and personal responsibility. One of the plaintiff's expert witnesses was Dr. Walter Fox, Director of the Arizona Mental Health Department and former president of the Association of Medical Superintendents of Mental Hospitals. He had interviewed Donaldson and examined his hospital record. Fox testified that confining Donaldson to a locked building with no opportunity for grounds privileges was not "consistent" with a treatment plan for a patient with Donaldson's history.

Gumanis denied Donaldson a privilege card, even after Donaldson had asked him for one. Fox testified that it would have been "standard psychiatric practice" to extend grounds privileges to a patient of Donaldson's background, condition, and history. Gumanis, in his testimony at trial, could not give a convincing explanation for his refusal of grounds privileges to Donaldson.[6] At one point he sought to shift the responsibility for the refusal to O'Connor's shoulders, saying that he recalled having denied privileges after consultation with O'Connor. Later, he testified that at the time in question Donaldson had appeared to him to be "really upset", and that

6. Donaldson testified that he had once escaped from the hospital. This occurred around Christmastime 1957, shortly before the end of the first year Donaldson had spent at Florida State. The hospital records, however, did not show that a fear Donaldson would attempt to escape again motivated the denial of grounds privileges; nor have Gumanis and O'Connor asserted before this Court that such a fear was their reason for denying Donaldson a card.

he had "probably" made the decision to deny Donaldson a privilege card on his own.

Donaldson testified that soon after his transfer to Department C, Dr. Hanenson, the physician in charge of that department, gave him a privilege card.

The second form of treatment denied Donaldson was occupational therapy. Donaldson testified that Gumanis consistently refused to allow him to enter occupational therapy. This testimony was borne out by a progress note entered in Donaldson's hospital record January 17, 1964. Again, Fox testified that given what he called Donaldson's "social history", Donaldson would have been ideally suited to benefit from occupational therapy. According to Donaldson, Gumanis did not want him to go into occupational therapy, because Gumanis feared that he would learn touch-typing and would use this skill, in Donaldson's words, to "write writs", that is, to prepare habeas corpus petitions. Gumanis gave no reason why he denied Donaldson occupational therapy, although in the course of his testimony he did allude to the fact that he had done so. Not until Donaldson was transferred to Dr. Hanenson's care was he allowed to enter occupational therapy.

Third, the simplest and most routine form of psychiatric treatment is to have a patient talk with a psychiatrist. Donaldson testified that in the eighteen months O'Connor was in direct charge of his case, he spoke with O'Connor "not more than six times", and that the total time he spent talking to O'Connor did not consume more than one hour. He testified that in the eight and one-half years he spent under Gumanis' care, he did not speak with Gumanis more than a total of two hours—an average of about fourteen minutes a year. He testified that neither Gumanis nor O'Connor ever heeded his requests to discuss his case. On one occasion Gumanis said that he "talked only to patients that he wanted to". Gumanis did not recall that conversation. Once again, there was evi-

dence to show that the situation improved when Donaldson was transferred to Dr. Hanenson's care. Donaldson testified that Hanenson managed to speak with him once a week, even though, according to Donaldson, patients were more numerous, psychiatrists fewer, and conditions worse in Hanenson's Department C than they had been in Gumanis' Department A.

B. *The defendants recklessly failed to attend to and treat Donaldson at precisely those junctures when treatment could have most helped Donaldson recover and therefore be released.*

The jury could have concluded that Donaldson should have been marked, at his entrance to the hospital, as a prime candidate for an early release, and that the defendants acted recklessly in failing to treat or attend to him during the early stage of his confinement. Fox testified that, given Donaldson's history,[7] he should have been "pegged" for an "early discharge". Moreover, a progress note entered by Gumanis after his first diagnostic interview with Donaldson, March 25, 1957, recorded that Donaldson "appeared" to be "in remission". Gumanis defined "remission" for the jury as a state "when the patient does not express delusions or paranoid ideas", and told the jury that it was hospital practice to release patients who were in remission. He testified that Donaldson was not released because he wanted to "observe [Donaldson] further". But after that interview the first progress note entered in Donaldson's hospital record is dated four months later; and the next report five months after that. Asked about this, Gumanis first replied, "When you have 900 patients you do that"; later, he insisted that he had seen Donaldson frequently, but had not recorded progress notes after each observation. The jury, however, could have dis-

7. Fourteen years before he was hospitalized in Florida, Donaldson had been hospitalized at the Marcy State Hospital in New York, with the same diagnosis as that made by the Florida doctors—"paranoid schizophrenic". On that occasion, Donaldson was released after three months.

counted this testimony and concluded that Gumanis acted wantonly in giving a patient who had appeared to be "in remission" the same treatment he gave his 900 other patients.

C. *The defendants wantonly, maliciously, or oppressively blocked efforts by responsible and interested friends and organizations to have Donaldson released to their custody.*

At issue here are two efforts made to secure Donaldson's release, one by Helping Hands, Inc., a Minneapolis organization which runs halfway houses for mental patients and John H. Lembcke, a college friend of Donaldson.

1. *The Helping Hands' attempt to obtain Donaldson's release.*

Helping Hands made an inquiry to the hospital concerning the possibility of releasing Donaldson to its custody by a letter dated June 6, 1963:

> We are interested in the possibility of signing out your patient, Kenneth Donaldson, and taking him as a resident at our halfway house at 3800 Columbus Avenue, Minneapolis. A maximum of six people live here, including our house mother, and myself, as president. At this time we have a room for Kenneth, who has interested us very much through his letters.

Enclosed with the letter was a brochure describing Helping Hands and a letter from the Minneapolis Clinic of Psychiatry and Neurology, stating that "it would be impossible in any of our State Hospitals for a patient to receive the type of attention and care" provided at Helping Hands. The author of this letter pointed out that the woman identified by the letterhead as the founder and director of Helping Hands had "rehabilitated well over a thousand over the years". The letter requested information concerning Donaldson's age, health, and "qualifications for work".

The hospital responded June 17, 1973, in a letter signed by O'Connor, then Clinical Director of the hospital. It gave

Donaldson's age, and answered inquiries concerning his health and qualifications for work with the bare statement that Donaldson was "mentally incompetent at the present time." The crisp concluding paragraph read:

> Should he [Donaldson] be released from this Hospital, he will require very strict supervision, which he would not tolerate. Such a release would be to the parents. We see no prospects of his release to any third party at any time in the near future.

The jury could have decided that Gumanis and O'Connor acted wantonly and maliciously in issuing this response, and that this conduct foreclosed an opportunity for Donaldson to win back at least a part of his freedom, and to gain access to a level of psychiatric treatment unavailable to him at the Florida Hospital. Each of the defendants sought to shift the responsibility for sending this curt reply to the other's shoulders. They discussed the question in terms of whether hospital rules, in general, fixed responsibility for deciding whether a patient could be furloughed by the attending physician, or the Superintendent or Clinical Director; they did not discuss it in terms of their recollections of the particular event. The jury would have been justified in finding the two jointly responsible for the incident.

2. *The Lembcke attempt to obtain Donaldson's release.*

John H. Lembcke, a certified public accountant, in Binghamton, New York, who is married and has three children, had been a classmate of Donaldson's at Syracuse University in the 1920's. On four occasions, Lembcke sought to have Donaldson released to his custody. The first was on July 3, 1964, when Lembcke informed the hospital that Donaldson was a friend of his, and inquired whether there were "any conditions under which he would be released so that I could bring him back to New York State". The same day the hospital received the letter, O'Connor pencilled a note to Gumanis that is

attached to the letter in Donaldson's hospital record. The note said:

> This man must not be well himself to want to get involved with someone like this patient, who even the recent visiting psychologist considered *dangerous*—Recommend turn it down.

Rich, the new Clinical Director, wrote Lembcke saying that Donaldson had "shown no particular changes mentally", and that if released he would "require complete supervision".

The second inquiry came by letter of November 27, 1964. Again O'Connor appended a note to Gumanis that is in the hospital records. This note gave three reasons for denying Lembcke's request to have Donaldson released to him: parental consent would be required; the patient "would not stay with party mentioned"; and "we don't know anything about party". Gumanis prepared a letter, dated November 27 and again signed by Dr. Rich, "advis[ing]" Lembcke that Donaldson would "require further hospitalization". The reply did not mention the three reasons for the denial set out in O'Connor's note, and did not request any further information from Lembcke, even though Lembcke in his November 23 letter had offered to provide any information the hospital should request.

The third attempt by Lembcke began with another letter to the hospital, dated December 21, 1965. According to Lembcke's testimony, the hospital responded by saying Donaldson could be released on two conditions: (1) that Lembcke would give Donaldson "adequate supervision" so that the release would not be detrimental to his mental health; and (2) that Lembcke would secure parental permission for Donaldson to go to New York with Lembcke. In May 1966, Lembcke went to Florida, and met with Gumanis and O'Connor. While in Florida he saw Donaldson and obtained from Donaldson's parents a letter dated May 14, 1966, giving their consent to Donaldson's being released to him. Nothing happened. In his

testimony Lembcke did not explain how or why he came to abandon this 1966 effort to secure his friend's release.

Lembcke's final and most important effort to secure Donaldson's release began in March 1968. On March 21, the General Staff, at a meeting attended by Gumanis and Hanenson but not by O'Connor, recommended Donaldson's release on a trial visit or out-of-state discharge. On March 24, Lembcke wrote the hospital renewing his offer to take Donaldson. On March 28, the hospital responded, imposing three conditions on Donaldson's release: (1) that Lembcke be willing to come for Donaldson; (2) that he be willing to supervise Donaldson; and (3) that he be willing to take Donaldson to a psychiatrist if Donaldson needed treatment. By letter of March 31, Lembcke acceded to these conditions. On April 4, the hospital replied with a letter imposing two additional conditions: (1) a detailed statement concerning the home supervision Donaldson would be given; and (2) written authorization for the release from Donaldson's parents. Lembcke wrote back giving the hospital the information about home supervision it requested. The hospital replied by again saying it would be necessary to obtain the written consent of Donaldson's parents.

On September 18, 1968, Lembcke wrote the hospital, enclosing a photocopy of the notarized written permission Donaldson's parents had signed May 14, 1966. The hospital responded in a letter dated September 24, signed by Dr. Rich. The letter informed Lembcke that Donaldson had been mentally ill for many years, that he "still express[ed] delusional thinking" and that "it would not be fair to you or to him to release him from the hospital at this time without adequate planning". The letter added, in its final paragraph, that it would be necessary for the hospital to have more recent authorization from Donaldson's nearest relative than the one Lembcke had proffered. At that point, Lembcke gave up; whenever he met the conditions imposed by the hospital officials, new

conditions were imposed. As he put it, "after requirements were met, requirements were increased".

One other facet of Lembcke's last attempt to secure Donaldson's release bears mention. As noted, O'Connor did not attend the Staff Conference which had recommended Donaldson's release March 21. O'Connor first learned of the hospital's recommendation in June, when Donaldson wrote to the Division Director of the hospital concerning the effort being made to release him. The division director forwarded the letter to O'Connor, who in turn forwarded it to Hanenson, asking for information concerning the proposed release. Hanenson responded with a memorandum dated June 17. Across the bottom of this memorandum, O'Connor pencilled in the remark, "the record will show, I believe, we have been through this before and decided Mr. Lembcke would not properly supervise the patient". It was not clear when O'Connor supposed this "decision" to have been made, and in his deposition O'Connor was unable to locate any record of it in the hospital record. Moreover, there were suggestions in the record that Dr. O'Connor's conduct, in this and other respects, was influenced by his knowledge of Donaldson's history of writing letters to the press and to outside officials. From all of this evidence, the jury would have been justified in concluding that the frustration of Lembcke's effort to secure Donaldson's release in 1968 was entirely or primarily the result of O'Connor's bad faith intervention or, at the least, that the intervention was in reckless disregard of Donaldson's rights.

D. *The defendants continued to confine Donaldson knowing he was not dangerous, or with reckless disregard for whether he was dangerous.*

Three of the plaintiff's expert witnesses—Fox, Raymond D. Flowler, Jr., Chairman of the Psychology Department at the University of Alabama and former President of both the Alabama and Southern Psychological Associations, and Julian Davis, Director of the Psychology Department at the Florida State Hospital—testified that they did not believe Donaldson

was dangerous. Fox's and Flowler's opinions were based upon readings of the hospital records, Donaldson's psychological reports, Donaldson's past history, and raw data from his psychological examination. Lembcke testified that in his half century of having known Donaldson, he had never known Donaldson to be "violent", "aggressive", or "belligerent"; that, on the contrary, he knew Donaldson to be a "gentle" man. Dr. Walls testified that he did not believe Donaldson was physically dangerous; Gumanis himself conceded that he did not think Donaldson dangerous while Donaldson was in the hospital, although he said he could not predict what Donaldson would be like outside the hospital. There was no evidence in the record of Donaldson's ever having been violent in any way.

On the basis of this testimony the jury would have been justified in finding that Donaldson was not dangerous, and in inferring that the defendants knew him to be so.

E. *The defendants did not do the best they could with available resources.*

As they did in the district court, the defendants on appeal pitch their defense in substantial part on their contention that they did the best they could with limited resources available to the state psychiatric hospital. Donaldson rebuts this contention, first, by pointing out the contrast between the treatment he received from the defendants and that he received from Hanenson. Hanenson allowed him grounds privileges and occupational therapy, spoke with him frequently, and within a year of taking charge of his case arranged a staff conference that recommended his release. Second, he relies on the testimony of Fox and the other experts to the effect that Gumanis and O'Connor failed to take steps that would have been open to them to take, even given the admittedly stark limitations on the resources available to them. We agree that these two considerations were a sufficient basis for the jury to reject the defendants' defense that they did the best they could with available resources.

We turn now to the novel and important question whether civilly committed mental patients have a constitutional right to treatment.

II.

[1] The theory of Donaldson's cause of action under section 1983 was set forth in three of the instructions given by the trial judge. The first, instruction number 34, was a variation of a standard form "boiler plate" instruction found in 2 Dewitt & Blackmer's Federal Jury Practice & Instructions, 1970, § 87.05 (2d ed.) This instruction stated that there were four basic elements Donaldson had to prove to make out a claim under § 1983: (1) that the defendants "confined plaintiff against his will, knowing that he was not mentally ill or dangerous, and knowing that if mentally ill he was not receiving treatment for his mental illness"; (2) that defendants "then and there acted under the color of state law"; (3) that defendants' "acts and conduct deprived the plaintiff of his federal constitutional right not to be denied his liberty without due process of law as that phrase is defined and explained in these instructions"; and (4) that the defendants' "acts and conduct were the proximate cause of injury and consequent damage to the plaintiff". The other two instructions, 37 and 38, were the relevant instructions "defin[ing] and explain[ing]" the "phrase", "federal constitutional right not to be denied or deprived of his liberty without due process of law", within the meaning of instruction 34. These instructions told the jury:

37. You are instructed that a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such individual treatment as will give him a realistic opportunity to be cured or to improve his mental condition.

38. The purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not dangerous to himself or others. Without such

treatment there is no justification, from a constitutional standpoint, for continued confinement.

The propriety of these two instructions is the heart of the question raised by both O'Connor and Gumanis in their appeals.[8]

[2] The question for decision, whether patients involuntarily civilly committed in state mental hospitals have a constitutional right to treatment, has never been addressed by any of the federal courts of appeals. Three district courts, however, have decided the question within the last three years, two of which held that there is a constitutional right to treatment.[9]

8. As a threshold matter, Donaldson suggests that the objections to these instructions are not properly before this Court. He notes that the defendants did not object to that instruction either when the proposed instructions were discussed in chambers, or after the charge was read to the jury. The defendants did, however, object to what were then the plaintiff's proposed instructions 37 and 38 in a pretrial brief filed before the Court. There they asked that those instructions be replaced with an instruction that "[y]ou are instructed that a person who is committed to a mental hospital has a right to be released through judicial process when through no fault of his own treatment is not afforded and he is not dangerous to society or to himself". The trial judge refused this request, and gave the two instructions as the plaintiffs had proposed them. It is settled that "a failure to object may be disregarded if a party's position has previously been made clear to the court and it is plain that a further objection would be unavailing". 9 C. Wright & A. Miller, Federal Practice & Procedure § 2553 at 639–40; see, *e. g.*, Mays v. Dealers Transit, 7 Cir. 1971, 441 F.2d 1344; Steinhauser v. Hertz Corp., 2 Cir. 1970, 421 F.2d 1169. We find that was the case here, and therefore we consider that the objections are properly before the Court.

9. Two cases hold that there is a right to treatment for civilly committed mentally ill patients. Wyatt v. Stickney, M.D.Ala.1971, 325 F.Supp. 781, *on submission of proposed standards by defendants*, 334 F.Supp. 1341, enforced, 1972, 344 F.Supp. 373, 387, appeal docketed sub nom., Wyatt v. Aderholt, No. 72–2634, 5 Cir. Aug. 1, 1972; Stachulak v. Coughlin, N.D.Ill., 1973, 364 F.Supp. 686. One has held civilly committed mentally ill patients enjoy no right to treatment. Burnham v. Department of Public Health, N.D.Ga.1972, 349 F.Supp. 1335, appeal docketed, No. 72–3110, 5 Cir., Oct. 4, 1972.

A fourth case has recently held that civilly committed mentally retarded patients have a right to treatment. Welsch v. Likins, No. 4–72–Civ. 451, D.Minn. Feb. 15, 1974, — F.Supp. —.

The Court of Appeals for the District of Columbia Circuit, in a case decided eight years ago, took note in dictum of the existence and seriousness of the question, although in the same case the court held that the Hospitalization of the Mentally Ill Act of 1964 [10] creates a *statutory* right to treatment on the part of mental patients in the District of Columbia.[11] The idea of a constitutional right to treatment has received an unusual amount of scholarly discussion and support,[12] and there is now an enormous range of precedent

10. D.C.Code Ann. § 21–501.

11. Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451. Chief Judge Bazelon wrote for the Court:

> Absence of treatment "might draw into question 'the constitutionality of [this] mandatory commitment section' as applied." (1) Lack of improvement raises a question of procedural due process where the commitment is under D.C.Code § 24–301 rather than under the civil commitment statute, for under § 24–301 commitment is summary, in contrast with civil commitment safeguards. It does not rest on any finding of present insanity and dangerousness but, on the contrary, on a jury's reasonable doubt that the defendant was sane when he committed the act charged. Commitment on this basis is permissible because of its humane therapeutic goals. (2) Had appellant been found criminally responsible, he could have been confined a year, at most, however dangerous he might have been. He has been confined four years and the end is not in sight. Since this difference rests only on need for treatment, a failure to supply treatment may raise a question of due process of law. It has also been suggested that a failure to supply treatment may violate the equal protection clause. (3) Indefinite commitment without treatment of one who has been found not criminally responsible may be so inhumane as to be "cruel and unusual punishment." [Footnotes and citations omitted]

Id. at 453.

12. The landmark article in the field is Birnbaum, The Right to Treatment, 1960, 46 A.B.A. Journal 499. Much of the commentary in the area was stimulated by the *Rouse* decision. *E. g.*, Symposium—The Right to Treatment, 1969, 57 Geo.L.J. 673 (11 articles, 218 pages); Bazelon, Implementing the Right to Treatment, 1969, 36 U.Chi.L.Rev. 742; Birnbaum, Some Remarks on "The Right to Treatment," 1971, 23 Ala.L.Rev. 623; Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 1969, 70 Mich.L.Rev. 1108; Katz, The Right to Treatment—An Enchanting Legal Fiction? 1969, U.Chi.L.Rev. 755; Drake, Enforcing the Right to Treatment: Wyatt v. Stickney, 1972, 10 Am.Crim.L.Rev. 587; Morris, "Criminality" and the Right to

relevant to, although not squarely in point with, the issue.[13] The idea has been current at least since 1960, since the publication in the May 1960 issue of the American Bar Association Journal of an article by Dr. Morton Birnbaum, a forensic medical doctor now generally credited with being the father of the idea of a right to treatment.[14] The A.B.A. Journal editorially endorsed the idea shortly after the publication of Dr. Birnbaum's article.[15]

We hold that a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition.

In reaching this result, we begin by noting the indisputable fact that civil commitment entails a "massive curtailment of liberty" in the constitutional sense. Humphrey v. Cady, 1972, 405 U.S. 504, 509, 92 S.Ct. 1048, 31 L.Ed.2d 394. The destruction of an individual's personal freedoms effected by civil commitment is scarcely less total than that effected by confinement in a penitentiary. Indeed, civil commitment, because it is for an indefinite term, may in some ways involve a more serious abridgement of personal freedom than imprisonment for commission of a crime usually does. Civil commitment involves stigmatizing the affected individuals, and the stigma attached, though in theory less severe than the stigma attached to criminal conviction, may in reality be as severe, or more so.[16] Since civil commitment involves deprivations of

Treatment, 1969, U.Chi.L.Rev. 784; Note, The Nascent Right to Treatment, 1967, 53 Va.L.Rev. 1134; Note, Civil Restraint, Mental Illness, and the Right to Treatment, 1967, 77 Yale L.J. 87; 80 Harv.L.Rev. 898 (1967).

13. See cases cited at nn. 23–44 *infra*.

14. Birnbaum, The Right to Treatment, 1960, 46 A.B.A.J. 499.

15. Editorial, A New Right, 1960, 46 A.B.A.J. 516.

16. On the recognition that stigmatization constitutes a deprivation of liberty in the constitutional sense, see Board of Regents v. Roth, 1972, 408 U.S. 564, 573, 92 S.Ct. 2701, 33 L.Ed.2d 548, 558 559.

liberty of the kind with which the due process clause is frequently concerned, that clause has the major role in regulating government actions in this area.

Beyond this, the conclusion that the due process clause guarantees a right to treatment rests upon a two-part theory. The first part begins with the fundamental, and all but universally accepted, proposition that "any nontrivial governmental abridgement of [any] freedom [which is part of the 'liberty' the Fourteenth Amendment says shall not be denied without due process of law] must be justified in terms of some 'permissible governmental goal.'" Tribe, Foreword—Toward a Model of Roles in the Due Process of Life and Law, 86 Harv.L.Rev. 1, 17 (1973). Once this "fairly sweeping concept of substantive due process" is assumed, *id.* at 5 n. 26,[17] the next step is to ask precisely what government interests justify the massive abridgement of liberty civil commitment entails. Typically, three distinct grounds for civil commitment are recognized by state statutes: danger to self; danger to others; and need for treatment, or for "care", "custody", or "supervision". Jackson v. Indiana, 1972, 406 U.S. 715, 737, 92 S.Ct. 1845, 32 L.Ed.2d 435; see Note, Civil Commitment of the Mentally Ill: Theories and Procedures, 1966, 79 Harv.L.Rev. 1288, 1289–97; Note, 1967, The Nascent Right to Treatment, 53 Va.L.Rev. 1134, 1138–39.[18] It is analytically useful to conceive of these grounds as falling into two categories; one a

17. *See also* Ely, The Wages of Crying Wolf: A Comment on Roe v. Wade, 1973, 82 Yale L.J. 920, 935 & n. 91; Roe v. Wade, 1973, 410 U.S. 113, 172–173, 93 S.Ct. 705, 35 L.Ed.2d 147 (Rehnquist, J., dissenting); Doe v. Bolton, 1973, 410 U.S. 179, 223, 93 S.Ct. 739, 35 L.Ed.2d 201 (White, J., dissenting).

18. In *Jackson*, the Supreme Court, relying upon an American Bar Foundation study, found that in nine states the sole criterion for involuntary commitment was the danger to self or others; that in 18 other states the patient's need for care or treatment was an alternative basis; that the need for care or treatment was the sole basis in six other states; and a few states had no statutory criteria at all and "presumably le[ft] the determination to judicial discretion". 106 U.S. at 737 n. 19, citing American Bar Foundation, The Mentally Disabled and the Law (rev. ed. 1971) at 36–49.

"police power" rationale for confinement, the other a "*parens patriae*" rationale.[19] Danger to others is a "police power" rationale; need for care or treatment a "*parens patriae*" rationale. Danger to self combines elements of both.

The key point of the first part of the theory of a due process right to treatment is that where, as in Donaldson's case, the rationale for confinement is the "*parens patriae*" rationale that the patient is in need of treatment, the due process clause requires that minimally adequate treatment be in fact provided. This in turn requires that, at least for the nondangerous patient, constitutionally minimum standards of treatment be established and enforced. As Judge Johnson expressed in the *Wyatt* case: "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process." Wyatt v. Stickney, *supra*, 325 F.Supp. at 785. Or as Justice Cutter, speaking for the Supreme Judicial Court of Massachusetts, put it: "Confinement of mentally ill persons, not found guilty of crime, without affording them reasonable treatment also raises serious questions of deprivation of liberty without due process of law. As we said in the *Page* case [citation omitted], of a statute permitting comparable confinement, 'to be sustained as a nonpenal statute . . . it is necessary that the remedial aspect of confinement . . . have foundation in fact.'" Nason v. Superintendent, Bridgewater Hospital, 1968, 353 Mass. 604, 612, 233 N.E.2d 908, 913. This key step in the theory also draws considerable support from, if indeed it is not compelled by, the Supreme Court's recent decision in Jackson v. Indiana, 1972, 406 U.S. 715, 92 S.Ct. 1845, 32 L.Ed.2d 435. In *Jackson*, the Supreme Court established the rule that "[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purposes for which the individual is

19. See Note, The Nascent Right to Treatment, 1967, 53 Va.L.Rev. 1134, 1138–39.

committed". 406 U.S. at 738.[20] If the "purpose" of commitment is treatment, and treatment is not provided, then the "nature" of the commitment bears no "reasonable relation" to its "purpose", and the constitutional rule of *Jackson* is violated.

[3, 4] This much represents the first part of the theory of a due process right to treatment; persons committed under what we have termed a *parens patriae* ground for commitment must be given treatment lest the involuntary commitment amount to an arbitrary exercise of government power proscribed by the due process clause. The second part of the theory draws no distinctions between persons committed under "*parens patriae*" rationales and those committed under "police power" rationales. This part begins with the recognition that, under our system of justice, long-term detention is, as a matter of due process, generally permitted only when an individual is (1) proved, in a proceeding subject to the rigorous constitutional limitations of the due process clause of the fourteenth amendment and the Bill of Rights, (2) to have committed a *specific act* defined as an offense against the state. See Powell v. Texas, 1968, 392 U.S. 514, 533, 542–543, 88 S.Ct. 2145, 20 L.Ed.2d 1254 (Black, J., concurring). Moreover, detention, under the criminal process, is usually allowed only for a period of time explicitly fixed by the prisoner's

20. *Jackson* involved a mentally defective deaf mute who was committed after the court determined that he was incompetent to stand trial. Since the mental and physical defects which were the cause of his inability were not susceptible to treatment and not likely to improve during his confinement, it was unlikely that he would ever become competent to stand trial. In the circumstances, the Supreme Court held that its rule that "the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed" permitted the state to confine Jackson under the provisions for the commitment of those found incompetent to stand trial only for "the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity [to stand trial] in the foreseeable future". It held further that even if it were determined that he was likely to become able to stand trial, "his continued commitment [would have to be] justified by progress toward that goal". 406 U.S. at 738.

sentence. The second part of the theory of a due process right to treatment is based on the principle that when the three central limitations on the government's power to detain—that detention be in retribution for a specific offense; that it be limited to a fixed term; and that it be permitted after a proceeding where fundamental procedural safeguards are observed—are absent, there must be a *quid pro quo* extended by the government to justify confinement.[21] And the *quid pro quo* most commonly recognized is the provision of rehabilitative treatment, or, where rehabilitation is impossible, minimally adequate habilitation and care, beyond the subsistence level custodial care that would be provided in a penitentiary.[22]

21. One theory is that commitment pursuant to civil statutes generally lacks the procedural safeguards afforded those charged with criminal offense. The constitutional justification for this abridgment of *procedural rights* is that the purpose of commitment is treatment. (Emphasis supplied).

Welsch v. Likins, No. 4-72-Civ. 451, D.Minn., Feb. 15, 1974, —— F.Supp. —— at ——. *See also* Inmates of Boys' Training School v. Affleck, D.R.I.1972, 346 F.Supp. 1354, 1368; Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451, 453 (Bazelon, C. J.); Note, Civil Restraint, Mental Illness and the Right to Treatment, 1967, 77 Yale L.J. 87, 90-91, 102-03 & nn. 62-63.

22. Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed "into a penitentiary where one could be held indefinitely for no convicted offense."

Wyatt v. Stickney, M.D.Ala.1971, 325 F.Supp. 781, 784, quoting Ragsdale v. Overholser, 1960, 108 U.S.App.D.C. 308, 281 F.2d 943, 950 (Fahy, J., concurring). *See also* cases cited in nn. 23-24 *infra*.

Of the various formulations of this "*quid pro quo*" theory we have found, perhaps the most successful is that made by Professor Nicholas Kittrie, writing specifically about confinement of juveniles, but articulating a theory equally applicable to civil commitment of mentally ill persons:

> Our society has increasingly divested certain groups from the traditional criminal justice court and, acting under its asserted role of *parens patriae*, substituted new therapeutic controls.
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> • • • • • • • • • • •
>
> A new concept of substantive due process is evolving in [this] therapeutic realm. This concept is founded upon a recognition of the concurrency between the state's exercise of sanctioning powers and its assumption of the duties of social responsibility. Its implication is that effective treatment must be the *quid pro quo*

This second part of the theory draws a wide range of support from a variety of precedents. The relevant cases have arisen in five major procedural contexts.

The earliest group of relevant cases consists of cases decided on habeas corpus petitions brought by citizens held under provisions for various kinds of "nonpenal" confinement, who were being held in correctional facilities for prisoners convicted of crimes. These cases uniformly held that, where detention is "nonpenal" in theory, the very least that is required is that the persons be confined in a facility other than a prison.[23]

Later cases expand the view of these cases by holding not only that persons held under provisions for "nonpenal" confinement be held elsewhere than in a prison, but that they must be held in places where the conditions are *actually* therapeutic.[24]

The third line of relevant cases are those where the constitutionality of various modern "nonpenal" statutes—notably sex-offender and defective-delinquent statutes—provide for the confinement of habitual criminal offenders to protect

for society's right to exercise its *parens patriae* controls. Whether specifically recognized by statutory enactment or implicitly derived from the constitutional requirements of due process, the right to treatment exists.

Kittrie, Can the Right to Treatment Remedy the Ills of the Juvenile Process? 1969, 57 Geo.L.J. 851-52, 870.

23. Benton v. Reid, 1956, 98 U.S.App.D.C. 27, 231 F.2d 780; Commonwealth v. Page, 1958, 339 Mass. 313, 159 N.E.2d 82; In re Maddox, 1958, 351 Mich. 358, 88 N.W.2d 470; *cf.* Miller v. Overholser, 1953, 92 U.S.App.D.C. 110, 206 F.2d 415.

24. But this mandatory commitment provision rests upon a supposition, namely, the necessity for treatment of the mental condition which led to the acquittal by reason of insanity. And this necessity for treatment presupposes in turn that treatment will be accorded.

Ragsdale v. Overholser, 1960, 108 U.S.App.D.C. 308, 281 F.2d 943, 950 (Fahy, J., concurring), quoted with approval, Darnell v. Cameron, 1965, 121 U.S.App.D.C. 58, 348 F.2d 64, 67 68, (Bazelon, C. J.); Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, 517, cert. dismissed as improvidently granted sub nom., Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791; Commonwealth v. Page, 1959, 339 Mass. 313, 317, 159 N.E.2d 82, 85.

society and to provide rehabilitative care. The decisions have upheld such statutes, but the courts have usually added the proviso that the constitutionality of the statute is conditioned upon the *realization* of the statutory promise of rehabilitative treatment.[25]

The fourth set of cases, highlighted by Rouse v. Cameron[26] and Nason v. Superintendent of Bridgewater State Hospital,[27] consists of cases where individuals under confinement have brought habeas corpus petitions challenging their confinement on the ground that they were not receiving treatment. This is a diverse group of cases; in most of them, the challenge to confinement for lack of treatment has been combined with challenges brought on other grounds, and often the other grounds are the subject of the decisions. Among these cases,

25. For those in the category [of defective delinquents] it [the defective delinquents statute] would substitute psychiatric treatment for punishment in the conventional sense and would free them from confinement, not when they have "paid their debt to society," but when they have been sufficiently cured to make it reasonably safe to release them. With this humanitarian and progressive approach to the problem no person who has deplored the inadequacies of conventional penological practices can complain. But a statute though "fair on its face and impartial in appearance" may be fraught with the possibility of abuse in that if not administered in the spirit in which it is conceived it can become a mere device for warehousing the obnoxious and antisocial elements of society. . . . *Deficiencies in staff, facilities, and finances would undermine the efficacy of the Institution and the justification for the law, and ultimately the constitutionality of its application.* [Footnotes omitted]
Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, 517, cert. dismissed as improvidently granted sub nom. Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791 (emphasis supplied). *See also* Davy v. Sullivan, M.D.Ala.1973, 354 F.Supp. 1320, (sex offender statute) (three-judge court).

26. 1966, 125 U.S.App.D.C. 366, 373 F.2d 451 (Bazelon, C. J.). The District of Columbia Circuit has reaffirmed its *Rouse* holding on numerous occasions. See, *e. g.*, In re Curry, 1971, 147 U.S.App.D.C. 28, 452 F.2d 1360; Covington v. Harris, 1969, 136 U.S.App.D.C. 35, 419 F.2d 617; Tribby v. Cameron, 1967, 126 U.S.App.D.C. 327, 379 F.2d 104; Dobson v. Cameron, 127 U.S.App.D.C. 324, 383 F.2d 519; Millard v. Cameron, 1966, 125 U.S.App.D.C. 383, 373 F.2d 468.

27. 353 Mass. 604, 233 N.E.2d 908 (1968) (Cutter, J.).

however, we have found none where any court has declared that no right to treatment exists, and we have found none explicitly recognizing a *constitutional* right to treatment. When they hold that there is a right to treatment, the cases usually either rest on statutory grounds, or are ambiguous as to whether they are resting upon statutory or constitutional grounds.[28] But in all cases, the courts have at least sustained the right of a petitioner to a hearing to develop the facts supporting his claim that he is not receiving treatment.[29]

Fifth, and last, among the groups of cases is the spate of recent cases brought as class actions in federal court, seeking broad forms of injunctive and declaratory relief requiring that adequate treatment be provided in state-run facilities. The cases have included attacks on conditions in many types of facilities—including facilities for the mentally ill,[30] the mentally retarded,[31] juvenile delinquents[32] or nondelinquent juveniles held as being "persons in need of supervision".[33]

28. *But see* Stachulak v. Coughlin, N.D.Ill.1973, 364 F.Supp. 686, a case of this kind, citing *Wyatt* and holding there is a constitutional right to treatment.

29. *E. g.*, Humphrey v. Cady, 1972, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394 (characterizing committed sex offender's claim that he was not receiving treatment a "substantial constitutional claim", and remanding for a hearing on, inter alia, that issue).

30. See cases cited in note 9 *supra*.

31. Wyatt v. Stickney, M.D.Ala.1972, 344 F.Supp. 387; Welsch v. Likins, No. 4-72-Civ. 451, D.Minn. Feb. 15, 1974, — F.Supp. —. *Contra*, New York State Ass'n for Retarded Children, Inc. v. Rockefeller, E.D.N.Y.1973, 357 F.Supp. 752.

32. Nelson v. Heyne, 7 Cir. 1974, 491 F.2d 352, aff'g N.D.Ind.1972, 355 F.Supp. 451; Inmates of Boys' Training School v. Affleck, D.R.I.1972, 346 F.Supp. 1354; Morales v. Turman, E.D.Tex.1973, 364 F.Supp. 166.

33. Martarella v. Kelley, S.D.N.Y.1972, 349 F.Supp. 575, enforced, 359 F.Supp. 478.

The closest the Supreme Court has come to speaking directly on the second, more important part of the due process right to treatment theory we articulate, came in In re Gault, 1967, 387 U.S. 1, 22

Taken together, these five sets of cases constitute a near unanimous recognition that governments must afford a *quid pro quo* when they confine citizens in circumstances where the conventional limitations of the criminal process are inapplicable. These five groups include cases decided by all levels of courts—the Supreme Court,[34] the courts of appeals,[35] the federal district courts,[36] and the state courts.[37] One or another of them concerns each of the major forms of "nonpenal confinement: from those with a heavy police power emphasis, such as

n. 30, 87 S.Ct. 1428, 18 L.Ed.2d 527, in which the Court, discussing the context of juvenile confinement, wrote:

> While we are concerned only with procedure before the juvenile court in this case, it should be noted that to the extent that the special procedures for juveniles are thought to be justified by the special consideration and treatment afforded them, there is reason to doubt that juveniles always receive the benefits of such a *quid pro quo* . . . . The high rate of juvenile recidivism casts some doubt upon the adequacy of treatment afforded juveniles
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> . . .
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> In fact some courts have recently indicated that appropriate treatment is essential to the validity of juvenile custody, and therefore that a juvenile may challenge the validity of his custody on the ground that he is not in fact receiving any special treatment.

34. Jackson v. Indiana, 1972, 406 U.S. 715, 92 S.Ct. 1845, 32 L.Ed.2d 435; Humphrey v. Cady, 1972, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394; McNeil v. Director, Patuxent Institution, 1972, 407 U.S. 245, 92 S.Ct. 2083, 32 L.Ed.2d 719.

35. *E. g.*, Nelson v. Heyne, *supra* note 39; Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, *cert. dismissed as improvidently granted* sub nom., Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791; Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 541.

36. *E. g.*, cases cited in nn. 9, 31–33, *supra*.

37. *E. g.*, Nason v. Superintendent, Bridgewater Hospital, 1968, 353 Mass. 604, 233 N.E.2d 908; Commonwealth v. Page, 1959, 339 Mass. 313, 159 N.E.2d 82; In re Maddox, 1958, 351 Mich. 358, 88 N.W.2d 470.

confinement of sex offenders [38] or defective delinquents,[39] of persons acquitted by reason of insanity,[40] or of persons held incompetent to stand trial; [41] those with a heavy *parens patriae* emphasis, such as confinement of the mentally retarded,[42] or of juveniles; [43] and those—such as civil commitment of the mentally ill [44]—with elements of both rationales behind them.

The appellants argue strenuously that a right to constitutionally adequate treatment should not be recognized, because such a right cannot be governed by judicially manageable or ascertainable standards. In making the argument, they rely heavily upon the Northern District of Georgia's decision in Burnham v. Department of Public Health, 1972, 349 F.Supp. 1335, 1341–1343. In *Burnham*, the district judge held that a class action seeking declaratory and injunctive relief requiring the Georgia Department of Public Health to provide treatment at Georgia mental hospitals presented a nonjusticiable controversy. He quoted Baker v. Carr, 1962, 369 U.S. 186,

38. *E. g.*, Humphrey v. Cady, 1972, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394; Davy v. Sullivan, M.D.Ala.1973, 354 F.Supp. 1320 (three-judge court); Commonwealth v. Page, 1959, 339 Mass. 313, 159 N.E.2d 82.

39. *E. g.*, Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, cert. dismissed as improvidently granted sub nom., Murel v. Baltimore City Crim. Ct., 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791.

40. *E. g.*, Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451 (Bazelon, C. J.); Darnell v. Cameron, 1965, 121 U.S.App.D.C. 58, 348 F.2d 64 (Bazelon, C. J.); Ragsdale v. Overholser, 1960, 108 U.S.App.D.C. 308, 281 F.2d 943 (Burger, J.).

41. Jackson v. Indiana, 1972, 406 U.S. 715, 92 S.Ct. 1845, 32 L.Ed.2d 435. *See also* Greenwood v. United States, 1956, 350 U.S. 366, 76 S.Ct. 410, 100 L.Ed. 412; United States v. Pardue, D.Conn.1973, 354 F.Supp. 1377; United States v. Jackson, N.D.Cal.1969, 306 F.Supp. 4.

42. *E. g.*, Wyatt v. Stickney, M.D.Ala.1972, 344 F.Supp. 387; Welch v. Likins, No. 4-72-Civ. 451, D.Minn. Feb. 15, 1974, noted, 42 U.S.L.W. 1141–42.

43. Cases cited in notes 32–33.

44. Cases cited in note 9 *supra*.

198, 82 S.Ct. 691, 700, 7 L.Ed.2d 663, for the proposition that determining whether a suit was justiciable requires determining whether "the duty asserted can be judicially identified and its breach judicially determined, and whether protection for the right asserted can be judicially molded". 349 F.Supp. at 1341, quoting 369 U.S. at 198. He then cited the ambiguity of the dictionary definition of treatment, a passage from a law review article noting the fact that there are as many as forty different methods of psychotherapy,[45] and a passage from the Supreme Court's decision in Greenwood v. United States, 1956, 350 U.S. 366, 76 S.Ct. 410, 100 L.Ed. 412, concerning the "tentativeness" and "uncertainty" of "professional judgment" in the mental health field.[46] He concluded: "[T]he claimed duty (i. e. to 'adequately' or 'constitutionally treat') defies judicial identity and therefore prohibits its breach from being judicially defined." 349 F.Supp. at 1342.

The defendants' argument can be answered on two levels. First, we doubt whether, even if we were to concede that courts are incapable of formulating standards of adequate

45. Levine [M. Levine, Psychotherapy in Medical Practice] lists 40 methods of psychotherapy. Among these, he includes physical treatment, medicinal treatment, reassurance, authoritative firmness, hospitalization, ignoring of certain symptoms and attitudes, satisfaction of neurotic needs and bibliotherapy. In addition, there are physical methods of psychiatric therapy, such as the prescription of sedatives and tranquilizers, the induction of convulsions by drugs and electricity, and brain surgery. *Obviously, the term "psychiatric treatment" covers everything that may be done under medical auspices—and more.*

If mental treatment is all the things Levine and others tell us it is, how are we to determine whether or not patients in mental hospitals receive adequate amounts of it?

Szasz, The Right to Psychiatric Treatment: Rhetoric and Reality, 1969, 57 Geo.L.J. 740, 741.

46. . . . [T]heir [two court-appointed psychiatrists] testimony illustrates the uncertainty of diagnosis in this field and the tentativeness of professional judgment. The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment.

Greenwood v. United States, 1956, 350 U.S. 366, 375, 76 S.Ct. 410, 415, 100 L.Ed. 412.

treatment in the abstract, that we could or should for that reason alone hold that no right to treatment can be recognized or enforced. There will be cases—and the case at bar is one—where it will be possible to make determination whether a given individual has been denied his right to treatment without formulating in the abstract what constitutes "adequate" treatment. In this case, the jury properly could have concluded that Donaldson had been denied his rights simply by comparing the treatment he received while he was under Gumanis's and O'Connor's care with that he received while under Hanenson's care; or it could have concluded that Donaldson's rights had been violated on the basis of the evidence that the defendants obstructed his release even though they knew he was receiving no treatment. Neither judgment required any *a priori* determination of what constitutes or would have constituted adequate treatment, and of course no such determination was made.

We do not, however, concede that determining what constitutes adequate treatment is beyond the competence of the judiciary. In deciding in individual cases whether treatment is adequate, there are a number of devices open to the courts, as Judge Bazelon noted in discussing the implementation of the statutory right to treatment in the landmark case of Rouse v. Cameron:

> But lack of finality [of professional judgment] cannot relieve the court of its duty to render an informed decision. Counsel for the patient and the government can be helpful in presenting pertinent data concerning standards for mental care, and, particularly when the patient is indigent and cannot present experts of his own, the court may appoint independent experts. Assistance might be obtained from such sources as the American Psychiatric Association, which has published standards and is continually engaged in studying the problems of mental care. The court could also consider inviting the psychiatric and legal communities to

establish procedures by which expert assistance can be best provided. [Footnotes omitted].

373 F.2d at 457. There are by now many cases where courts have undertaken to determine whether treatment in an individual case is adequate or have ordered that determination to be made by a trial court.[47] Even in cases like *Wyatt* and *Burnham*, when courts are asked to undertake the more difficult task of fashioning institution-wide standards of adequacy, the task should not be beyond them. The experience of the *Wyatt* case bears this out. In *Wyatt*, agreement was reached among the parties on almost all of the minimum standards for adequate treatment ordered by the district court, and the defendants joined in submitting the standards to the district court. These stipulated standards were supported and supplemented by testimony from numerous expert witnesses. Moreover, there was a striking degree of consensus among the experts, including the experts presented by the defendants, as to the minimum standards for adequate treatment. The standards developed have not been challenged by the defendants in the appeal now pending before this Court. See Wyatt v. Stickney, M.D.Ala.1972, 344 F.Supp. 373, 375–376.

In summary, we hold that where a nondangerous patient is involuntarily civilly committed to a state mental hospital, the only constitutionally permissible purpose of confinement is to

47. See, *e. g.*, Humphrey v. Cady, 1972, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394; In re Curry, 1971, 147 U.S.App.D.C. 28, 452 F.2d 1360; United States v. Waters, 1970, 141 U.S.App.D.C. 289, 437 F.2d 722; Dobson v. Cameron, 1967, 127 U.S.App.D.C. 324, 383 F.2d 519; Tribby v. Cameron, 126 U.S.App.D.C. 327, 379 F.2d 104; Millard v. Cameron, 1966, 125 U.S.App.D.C. 383, 373 F.2d 468; Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, remanding, D.Md., 1969, 295 F.Supp. 389, aff'd sub nom., Tippett v. Maryland, 1971, 436 F.2d 1153, cert. dismissed as improvidently granted sub nom., Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791; Dixon v. Atty. Gen'l of Pennsylvania, M.D.Pa.1971, 325 F.Supp. 966 (three-judge); In re Jones, D.D.C.1972, 338 F.Supp. 428; Clatterbuck v. Harris, D.D.C.1968, 295 F.Supp. 84; Nason v. Supt. of Bridgewater State Hospital, 1968, 353 Mass. 604, 233 N.E.2d 908.

provide treatment, and that such a patient has a constitutional right to such treatment as will help him to be cured or to improve his mental condition. We hold that the district court did not err in so instructing the jury.

III.

[5] Gumanis and O'Connor join in contending that the evidence at trial did not permit the jury to find that they acted in bad faith, and that therefore they cannot be held personally liable for Donaldson's injuries or the deprivations of his constitutional rights. Gumanis's arguments concern primarily his role in deciding whether Donaldson could or should be released. He asserts that he acted throughout in good faith and in the reasonable belief that Donaldson was mentally ill and required further confinement. O'Connor's argument is directed not only toward his acts affecting the decision whether to release, but also to the entirety of his conduct while Donaldson was held at Florida State. O'Connor argues that both he and Gumanis did the best they could with available resources, and therefore should not be held personally liable for whatever was done to Donaldson. He cites in his brief the various limitations of staff and funds available to the state psychiatrists at Florida State, the difficulties hospital administrators have had in winning approval of their budgets from the state legislatures, and similar matters; and he argues, on that basis, that the denial of whatever right to treatment Donaldson had was the product of the actions of the legislature and of the realities of the budgetary situation, and not of the actions of the state psychiatrists to whose care Donaldson was entrusted.

We find the appellants' objection, in all of its various forms, without merit.

The trial judge instructed the jury:

> The defendants in this action rely on the defense that they acted in good faith. Simply put, defendants contend they in good faith believed it was necessary to detain

plaintiff in the Florida State Hospital for treatment for the length of time he was so confined. If the jury should believe from a preponderance of the evidence that defendants reasonably believed in good faith the detention of plaintiff was proper for the length of time he was confined then a verdict for defendants should be entered even though the jury may find the detention to have been unlawful.

However, mere good intentions which do not give rise to a reasonable belief that detention is lawfully required cannot justify plaintiff's confinement in the Florida State Hospital. As a corollary plaintiff here need not show malice or ill-will to prove his action under the Civil Rights Act. All that is required is that he demonstrate state action which amounts to an actual deprivation of constitutional rights or other rights guaranteed by law.

The defendants did not object to this instruction, and do not challenge its correctness here.[48] The instruction was proper, and that there was sufficient evidence to support a jury finding that the defendants did not act at all times in a good faith and reasonable belief that Donaldson needed continued confinement and that continued confinement was lawful. In effect, the jury found, on the facts, that Donaldson's right to treatment was denied not, or not only by the limitations of funds and staff and resources under which the hospital operated, but also by the actions of Gumanis and O'Connor themselves.

We are "duty bound to accept all evidence in favor of the verdict as true and to give such evidence the benefit of all permissible inferences that would help sustain the jury's deci-

48. Dowsey v. Wilkins, 5 Cir. 1972, 467 F.2d 1022, 1025-1026.

sion". Little v. Green, 5 Cir. 1970, 428 F.2d 1061, cert. denied, 400 U.S. 964, 91 S.Ct. 366, 27 L.Ed.2d 384; Grey v. First National Bank, 5 Cir. 1968, 393 F.2d 371, 381. We hold therefore that the evidence supported the jury's finding that the defendants did not act in good faith.

IV.

The first contention made by Gumanis alone is that the Northern District of Florida's jury selection plan operated to abridge his right to a jury trial under the seventh amendment and under 28 U.S.C. §§ 1861, 1862, by permitting the "systematic exclusion" of physicians from the jury rolls. Gumanis raised his objection to the composition of the jury on the first day of the trial, but after the jury had been impanelled and sworn. The Northern District selection plan allows certain specified classes of person, including "actively engaged members of the clergy" and "actively practicing attorneys, physicians, and dentists, and registered nurses", to be excused from jury duty if they so desire. The authority for these exceptions is an express provision of the Jury Selection and Service Act. 28 U.S.C. § 1863(b)(5) provides that a jury selection plan shall "specify those groups of persons or occupational classes whose member shall, on individual request therefore be excused from jury service. . . . if the district court finds, and the plan states, that jury service by such class or group would entail undue hardship or extreme inconvenience. . . ."

[6, 7] There is no merit to the defendant's contention. The trial court correctly held that the objection was not timely raised, since the defendants had not mentioned it until after the jury was impanelled. See Brooks v. United States, 5 Cir. 1969, 416 F.2d 1044, 1047. We also agree with his ruling that the jury selection plan was in compliance with the statute.

V.

Gumanis next objects to the trial court's refusal to instruct the jury that Donaldson's claim was barred by the statute of limitations.[49] This contention is premised upon the fact that Donaldson was taken out of his care April 18, 1967, more than four years before the filing of the First Amended Complaint in this case, and about five years before the complaint was amended to add Gumanis as a defendant.

Since there is no statute of limitations provided under § 1983, federal courts adopt the statute of limitations of the state where the action arose,[50] and apply the "resemblance test" to decide which state statute is an appropriate one to apply.[51] In this case, the parties agree that the limitation period should be taken from one of three state statutes: the two-year statute applicable to both false imprisonment actions and to actions for medical malpractice; or the three-year statute applicable to actions upon liabilities created by statute; or the four-year statute applicable to miscellaneous actions not specifically provided for elsewhere in the Florida statute of limitations chapter.[52] Gumanis argues that it is irrelevant which of these 3 periods we apply, since even if the

49. The instruction in question read:
You are instructed that the statute of limitations for the wrongs alleged in the complaint are for the period of four (4) years, and that the defendants should not be held accountable for any damages which occurred from wrongs occurring prior to the four (4) year period preceding the complaint.
Donaldson argues that the defendants' objection to the trial judge's refusal to give this instruction is not properly before this Court, again because no objection was made to the trial judge's failure to give the instruction either at the charge conference or after the charge was read to the jury. See note 8 *supra*. Again, however, defendants' pretrial brief advised the court of the defendants' position, and again we hold that that sufficed to excuse the failure to object. See note 8 *supra*.

50. Campbell v. Haverhill, 1895, 155 U.S. 610, 15 S.Ct. 217, 39 L.Ed. 280.

51. See, *e. g.*, Smith v. Cremins, 9 Cir. 1962, 308 F.2d 187.

52. Fla.Stat. § 95.11(4), (5)(a), (6), F.S.A.

longest, the four-year statute, is applied, the period of limitations had elapsed by the time Gumanis was added as a defendant in this suit. Donaldson agrees that it is irrelevant which statute is chosen, since the limitation did not begin to run until July 31, 1971, the date Donaldson was released from the hospital. Donaldson therefore argues that the suit was timely brought, even if the two-year limitation period applies.

[8–10] We agree with Donaldson that the limitation period, be it two, three, or four years, did not begin to run until July 31; Donaldson's cause of action did not accrue until that time. When a tort involves continuing injury, the cause of action accrues, and the limitation period begins to run, at the time the tortious conduct ceases. See, *e. g.*, Fowkes v. Pennsylvania R. R. Co., 3 Cir. 1959, 264 F.2d 397. In the case of false imprisonment, the tort action this case most resembles, the cause of action does not accrue until the release of the imprisoned party.[53]

[11] We have found no Florida decision addressing the question when a cause of action for false imprisonment accrues. But in a § 1983 suit, even though a state statute is applied, the question when a federal cause of action *accrues* is a matter of federal, not state law.[54] The state statute is applied in the first place not as a matter of legal compulsion, but merely as a matter of convenience; there is no other period of limitation available.[55] We hold that in a case such as

53. See, *e. g.*, Bronaugh v. Harding Hospital, Inc., 1958, 12 Ohio App.2d 110, 231 N.E.2d 487; Mobley v. Broome, 1958, 248 N.C. 54, 102 S.E.2d 407; Matovina v. Hult, 1955, 125 Ind.App. 236, 244, 123 N.E.2d 893; Belflower v. Blackshere, Okl.1955, 281 P.2d 423, 425; Oosterwyk v. Bucholtz, 1947, 250 Wis. 521, 525, 27 N.W.2d 361; Jedzierowski v. Jordan, 1961, 157 Me. 352, 172 A.2d 636.

54. See, *e. g.*, Rawlings v. Ray, 1941, 312 U.S. 96, 61 S.Ct. 473, 85 L.Ed. 605; Cope v. Anderson, 1947, 331 U.S. 461, 67 S.Ct. 1340, 91 L.Ed. 1602; Sandidge v. Rogers, S.D.Ind.1958, 167 F.Supp. 553, 556; 2 Moore's Federal Practice ¶ 3.07(2) at 750.

55. See McAllister v. Magnolia Petroleum Co., 1958, 357 U.S. 221, 228–230, 78 S.Ct. 1201, 2 L.Ed.2d 1272 (Brennan, J., concurring); 2 Moore's Federal Practice ¶ 3.07(2).

this one, where a tort causing continuing injury is alleged, a patient's cause of action does not accrue until the date of his release.

VI.

[12] Gumanis next contends[56] that the district court erred in refusing to instruct the jury that he and the other defendants were entitled to a defense of quasi-judicial immunity under the Civil Rights Acts. At issue is defendant's proposed instruction number 11, which read:[57] "If you find that the defendants were operating in a quasi-judicial function, in that they, under state law, were making a judgment as to whether or not plaintiff should be released, defendants are immune from liability under the Civil Rights Act."

Gumanis relies primarily upon three Ninth Circuit cases. The first and most important is Hoffman v. Halden, 1969, 268 F.2d 280, in which the Ninth Circuit held that the superintendent of a state mental hospital, who allegedly had wrongfully detained a patient committed under a valid judicial commitment order, was immune from liability. The superintendent was empowered to release the patient when, in his own judgment, he found the patient no longer in need of confinement. The Court held that because he had been exercising a "discretionary" function, the Superintendent was immune from liability. The other two Ninth Circuit cases, Silver v. Dickson, 1968, 403 F.2d 642, and Keeton v. Procunier, 1971, 468 F.2d 810, held that members of state parole boards are immune from § 1983 liability, on the ground that the threat of liability would "exert a restricting influence on the overall functioning of the agency". *Silver*, 403 F.2d at 643.

56. Once again, Donaldson argues that the objection to the refusal to give the instruction is not properly before the Court. See notes 8, 49 *supra*. Once again, we hold that the trial judge was sufficiently apprised of the defendants' objections for us to consider the objection as having been preserved. See notes 8, 49 *supra*.

57. The full instruction is quoted in part III *supra*.

[13] Gumanis's argument is essentially that he is entitled to the defense, available to state officials in most common law jurisdictions, of absolute immunity for acts done in the performance of a "discretionary"—as opposed to a "ministerial" —function. See, *e. g.*, Barr v. Matteo, 1959, 360 U.S. 564, 79 S.Ct. 1335, 3 L.Ed.2d 1434 (immunity for federal officials as a matter of federal common law). For discussions of the common law rule, see Norton v. McShane, 5 Cir. 1964, 332 F.2d 855, 857–861 (Rives, J.); Anderson v. Nosser, 5 Cir. 1971, 438 F.2d 183, 198–200 (Goldberg, J.); modified en banc on other grounds, 1972, 456 F.2d 835; Carter v. Carlson, 1971, 144 U.S.App.D.C. 388, 447 F.2d 358, 361–365; 2 F. Harper & F. James, The Law of Torts § 29.10 at 1638–46 (1956). We must reject Gumanis's argument, however, because we have consistently held that the full range of officials immunities available at common law do not apply in actions brought under § 1983. Roberts v. Williams, 5 Cir. 1972, 456 F.2d 819, 830; *Anderson, supra*, 438 F.2d at 201; *Norton, supra*, 332 F.2d at 860–861 (dictum). In taking this position we have been joined by all the other circuits that have considered the question. *Carter, supra*, 447 F.2d at 365; Dale v. Hahn, 2 Cir. 1971, 440 F.2d 633; Kletschka v. Driver, 2 Cir. 1969, 411 F.2d 436, 448; Jobson v. Henne, 2 Cir. 1966, 355 F.2d 129, 133–134; McLaughlin v. Tilendis, 7 Cir. 1968, 398 F.2d 287; Donovan v. Reinbold, 9 Cir. 1970, 433 F.2d 738.

Official immunity has been restricted under § 1983, because that provision is directed at actions "under color of any statute, ordinance, regulation, custom, or usage of any State or Territory", and provides that "every person" subjecting another to a deprivation of constitutional rights shall be liable. See Francis v. Lyman, 1 Cir. 1954, 216 F.2d 583, 587; *Jobson, supra*, 355 F.2d at 133; *Anderson, supra*, 438 F.2d at 201; *Hoffman, supra*, 268 F.2d at 300. It has been the view of the courts that recognizing broad judicial immunities "would prac-

tically constitute a judicial repeal" of § 1983, since state officers are likely to be the primary persons found acting "under color of" law. *Hoffman, supra*, at 300; *Jobson, supra*, 355 F.2d at 134. Accordingly, the courts have repudiated what the district court for the District of Nevada has called the "discretionary act test" for determining when official immunity is appropriate in § 1983 cases. Adamian v. University of Nevada, 1973, 359 F.Supp. 825, 834. Instead, we and other courts have applied what the *Adamian* court called the "good faith for qualified governmental immunity" test, allowing immunity when (1) the officer's acts were discretionary; *and* (2) the officer was acting in good faith. Here, as noted above, the trial judge instructed the jury to find for the defendants if it found the defendants acted in good faith; and, again as noted above, the defendants have not challenged the propriety or phrasing of this instruction. That instruction was all that was required by this Court's version of the doctrine of "quasi-judicial" or "official" immunity from Civil Rights Act liability.[58]

58. It is appropriate to say in this context that we do not view the *Hoffman, Silver*, and *Keeton* cases as sound authority for a contrary result. The Ninth Circuit has made it clear that Hoffman and Silver do not "stand for the broad principle that all public officials are immune from Civil Rights Act liability if their acts were discretionary and done within the scope of their official duties". Donovan v. Reinbold, 9 Cir. 1970, 433 F.2d 738, 744. The Second Circuit had earlier stated its view that it would have disapproved the *Hoffman* decision if that decision had to be read to mean that "all subordinate state officials should be granted an immunity for all discretionary acts". *Jobson, supra*, 355 F.2d at 134 n. 11. And we ourselves have already once stated our view that *Hoffman* represented a "questionabl[e] resol[ution]" of the problem of official immunity under the Civil Rights Act. Norton v. McShane, 5 Cir. 1964, 332 F.2d 855, 861 n. 9, (Rives, J.). To the extent that *Hoffman*, by implying that state mental health officials should enjoy some form of "quasi-judicial. immunity", is read as authority for a result contrary to the one we reach here, we decline to follow it. We rely instead on *Dale* and *Jobson*, where the Second Circuit held state psychiatrists and mental hospital officials were not entitled to immunity under § 1983.

VII.

[14] The remainder of the objections Gumanis raises pose little difficulty. Gumanis contends that the trial judge erred in allowing the jury to award punitive damages. The objection is without merit. The trial judge instructed the jury that it could award punitive damages if it found that the defendants had acted "maliciously", "wantonly", or "oppressively". The instruction was proper as a matter of law, and there was ample evidence, some of it recited in our statement of facts above, to support a jury finding that the defendants' acts were "malicious", "wanton", or "oppressive".

[15] Gumanis argues that Donaldson's failure to receive treatment was a result largely of his own refusal, on religious grounds, to accept certain forms of treatment, particularly medication and electroshock treatments, and his failure to petition for restoration of his competency under Fla.Statutes § 394.22, F.S.A. Neither argument has any merit. As for Donaldson's refusal of forms of treatment, the trial judge instructed the jury: "You are instructed that if Plaintiff through his own actions contributed to the withholding of a particular form of treatment, that Plaintiff is not entitled to collect compensation from the Defendants for the failure to give such treatment during the particular period or periods Plaintiff refused such treatment." Gumanis did not at the trial and does not now object to this instruction. We find no reason to believe that either the verdict or the award of damages was based upon the failure to give Donaldson those forms of treatment he refused. As for his failure to petition for a restoration of his competency, the statute in question does not permit a person adjudged incompetent to petition on his own for a restoration of his competency; the petition may be instituted only by a parent, guardian, or "next friend". Donaldson cannot be held accountable for not doing what he was legally unable to do.

Finally, Gumanis contends that "the cumulative effect of certain errors and irregularities during the course of the trial

was such as to significantly undermine the fairness of the trial itself". We have considered these alleged errors too, and find no merit to any one of them. We have also concluded, upon a review of the record, that cumulatively they did not affect the fairness of the trial to any appreciable extent.

The judgment of the district court is

Affirmed.

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United States Court of Appeals

FOR THE FIFTH CIRCUIT

October Term, 1973

No. 73-1843

D. C. Docket No. CA 1693

KENNETH DONALDSON,
Plaintiff-Appellee,

versus

J.B. O'CONNOR, M.D. and JOHN GUMANIS, M.D.,
Defendants-Appellants.

Appeals from the United States District Court for the
Northern District of Florida

Before RIVES, WISDOM and MORGAN, Circuit Judges.

J U D G M E N T

This cause came on to be heard on the transcript of the record from the United States District Court for the Northern District of Florida, and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, affirmed.

April 26, 1974

Issued as Mandate: